Mississippi's Part C
State Performance Plan
2005-2010

First Steps

Mississippi Department of Health
Office of Health Services
Bureau of Child and Adolescent Health
Early Intervention Division

January 30, 2006

INTERAGENCY COORDINATING COUNCIL
CERTIFICATION OF ANNUAL REPORT

On behalf of the Interagency Coordinating Council (ICC) of Mississippi, I certify that the ICC agrees/ ~~disagrees~~ (*) with the information in the State's Annual Performance Report for Federal Fiscal Year 2005. The ICC understands that 34 CFR §80.40, of the Education Department General Administrative Regulations, requires that the lead agency prepare an Annual Performance Report containing information about the activities and accomplishments of the grant period, as well as how funds were spent. The ICC has reviewed the Report for completeness of its contents and accuracy.

We submit this Report in fulfillment of our obligation under Section 641(e) of the Individuals with Disabilities Education Act to submit an annual report to the Secretary and to the Governor on the status of the State's early intervention program for infants and toddlers with disabilities and their families.

Signature of ICC Chairperson

January 20, 2006
Date

(*) The Council may submit additional comments related to the Lead Agency's Annual Performance Report and append comments to the Report.

Overview of Part C in Mississippi

The Mississippi Department of Health (MDH) is the designated Lead Agency for the state's early intervention system established under Part C of the Individuals with Disabilities Education Act. First Steps, Mississippi's early intervention program, is administered through nine Public Health Districts throughout the state. Through the nine offices, children and families in every county in Mississippi can access early intervention supports and services. Funds are distributed to these public health district offices annually to coincide with the state fiscal year (July 1-June 30) to ensure statewide implementation of the Part C Early Intervention Program. District Administrators supervise District Coordinators, who are primarily responsible for administering the district early intervention program. District Coordinators supervise Service Coordinators, who are employed or contracted specifically to perform the duties of service coordination. Contracts are executed at the district and state level for services, including evaluation, assessment, Individualized Family Service Plan (IFSP) development, and services to children and families. State and private agencies provide services funded through Part C monies, state funding sources, Medicaid, and insurance.

Department of Health Central Office personnel, who perform the functions of overview, guidance, support, monitoring, training and technical assistance to the public health districts, include the Part C Coordinator, three Branch Directors, the Data Manager, three Operations Management Analysts Seniors, and an Administrative Assistant. Contractual staff reporting to the Central Office includes three Quality Monitors who have been instrumental in facilitating change. Early intervention supports and services are provided in accordance with Part C statute and regulations, and state policies and standards.

The Early Hearing Detection and Intervention Program in Mississippi (EHDI-M) is housed in the Mississippi Department of Health Central Office, with the Part C Coordinator acting as Project Director for EHDI-M. One Hearing Screening Coordinator collects data from the hospitals. One Diagnostic/Intervention Coordinator collects information from Audiologists. Both coordinators provide relevant information to five Hearing Resource Consultants (HRCs), who provide consultative services to families of children with hearing loss. More than 96% of all infants born in Mississippi hospitals are screened, with results reported to the EHDI-M office. Infants who do not pass both newborn hearing screens are brought back to the hospital for a third screen following discharge. Infants who fail the third screen are referred for an Audiology follow-up. The HRCs start working with families soon after failure of the third screen. Infants and toddlers who are diagnosed with a bilateral hearing loss are referred to First Steps. Infants and toddlers who are diagnosed with unilateral hearing loss are considered to be at-risk, unless they have other diagnoses/delays, and can be referred to the Department of Mental Health's EI program, which serves infants/toddlers identified as "at risk."

Currently two groups provide training and technical assistance to the First Steps program--University of Southern Mississippi/Institute for Disabilities Studies (USM/IDS) and WilloTEAM (the multidisciplinary evaluation/assessment team at Willowood Center in Jackson, MS). District Coordinators, Service Coordinators, Service Providers, Quality Monitors, and Central Office Staff took part in several trainings during the past year that emphasized play-based assessment and transdisciplinary practices. District, regional and statewide meetings were used to disseminate information, to explain changes, and to provide a forum for stakeholders to ask questions and problem solve. A statewide meeting in December was used as a forum to update stakeholders on the state of early intervention in Mississippi. Approximately ninety individuals representing diverse interests attended that meeting. The SPP process was explained in depth at the December meeting. Mississippi has been under an Improvement Plan since July 2005 to address long-standing non-compliance. Progress on the Improvement Plan was discussed, along with plans for further improvement.

Hurricane Katrina struck Mississippi on August 29, 2005. District IX, the six southern counties, was most significantly impacted. About one-third of the state suffered tremendous property damage and substantial damage to the infrastructure. Five months after the storm, the coast is still very much in recovery mode. Staff from OSEP was in Mississippi in November to access Mississippi's needs as a result of Hurricane Katrina, and to evaluate our performance on the Improvement Plan. Because of Hurricane Katrina, paper records, computers, and electronically recorded data were lost in the coastal region. The FFY 2005 data

reflect those losses. Starting in July 2005, the First Steps Information System (FSIS) was moved to a centralized system, so data are stored on a server in the Central Office in Jackson. Districts were in the process of "moving" data from the old system, which required saving data on computers and on disks, and importing and exporting data, when the hurricane struck.

District IX, the coastal region, is working to "recreate" electronic and paper data using provider records that were not lost, and data that had been previously supplied to the Central Office. Although raw data were certainly affected, it appears that the percentages for the state are accurate reflections of the system as a whole. Prior to the storm, District IX was one of the most densely populated districts in Mississippi. There were two pilot projects using promising collaborative partnerships with Part B and Department of Mental Health (DMH). Losses to all programs in District IX impacted not only the district, but progress throughout the state. The most significant impact was personal—affecting the lives of children, families, providers and EI staff. According to the State Demographer, based on research done in Florida, it could take five to ten years for the population to return to pre-storm numbers and for the infrastructure to recover.

Overview of State Performance Plan Development

Due to the effects of Hurricane Katrina, Mississippi was given an extension for submission of the SPP. Originally due on December 2, 2005, the SPP deadline was extended to January 30, 2006. On October 25-26, 2005, thirty-one stakeholders representing diverse interests were invited to participate in the development of the framework of Mississippi's State Performance Plan. Represented were parents and family members, advocates, service coordinators, service providers, district coordinators, monitors, technical assistance and training staff, university training personnel, staff from other state agencies (including Mental Health and the 619 Coordinator from Part B), Comprehensive System of Personnel Development (CSPD) committee members, and Central Office staff, including OMAS, Branch Directors, the Data Manager, and the Part C Coordinator. The makeup of the group reflected geographic, gender, age, and ethnic diversity. Also attending was Betsy Ayankoya, a Technical Assistant from the National Early Childhood Technical Assistance Center (NECTAC), who provided on-site technical assistance for the group.

All invited participants attended the retreat and were active in the process of providing an overview or description of the issue, process, or system; identifying areas in need of improvement; describing activities and strategies for improvement; and setting measurable and rigorous targets. A survey of the stakeholders indicated that the majority of participants felt that the process helped them to better understand the system of early intervention, to contribute to the future of the program, and to have their voice heard.

Once Central Office staff compiled the information from the stakeholder's meeting, draft versions of the SPP were shared through email distribution with an even wider group of stakeholders, including Department of Health personnel and the members of the SICC. Review and feedback were requested. The State Interagency Coordinating Council met on January 20, 2006, to review the SPP and to make additional recommendations. Recommendations received from contributing stakeholders were incorporated into the final SPP. The final version of the SPP will be disseminated electronically for distribution throughout the state. It will also be posted to the Mississippi Department of Health's website. In the future the Annual Performance Reports and results of monitoring will be posted to the website. Reports will specify the performance of individual districts, including data disaggregated by indicator.

Currently the state is designated as a "high risk grantee," and is working to improve performance and compliance on several indicators and other requirements of the grant. Five performance and compliance indicators being reported on a monthly Progress Report Card include "Number of New IFSPs (Child Find)," "45-Day Timeline," "Timely Provision of Services," "Natural Environment," and "Timely and Accurate Data." Significant improvements have been made in most areas. For the SPP, FFY 2004 data (July 1, 2004 through June 30, 2005) are reported; however, the discussion of the baseline data includes the latest data from the Improvement Plan Report Card (July 1, 2005 through December 31, 2005). Measurable and Rigorous Targets were set considering both the FFY 2005 baseline data and the current

data from the Improvement Plan. Stakeholders considered the activities and strategies developed for the Improvement Plan in writing the SPP.

Procedures and tools for a system of Focused Monitoring will be written by the end of March and should be available for OSEP's review on April 14, 2006, along with results of the Improvement Plan. A schedule for Monitoring visits has already been projected, based on the current data for each district. Monitoring visits will begin in May 2006. All districts will be monitored within the current federal fiscal year. Reports, including recommendations for improvement, resulting from Monitoring visits will be published on the agency's website.

Mississippi's Part C State Performance Plan for 2005-2010

Monitoring Priority: Early Intervention Services In Natural Environments

Indicator 1: Percent of infants and toddlers with IFSPs who receive the early intervention services on their IFSPs in a timely manner.

(20 USC 1416(a)(3)(A) and 1442)

Measurement:

Percent = # of infants and toddlers with IFSPs who receive the early intervention services on their IFSPs in a timely manner divided by the total # of infants and toddlers with IFSPs times 100.

Account for untimely receipt of services.

Overview of Issue/Description of System or Process:

1. Current training opportunities within health districts include research-based practices for multidisciplinary and transdisciplinary teams for evaluation and assessment, IFSP development, and service delivery.

2. Fields are being added to the First Steps Information System (FSIS) to capture information regarding timely provision services in accordance with the newly adopted state definition.

3. The First Steps Early Intervention Program Standards and Procedures, Revised May 2001, Section 7.42, require that the IFSP include the projected dates of initiation of the services listed under early intervention services (to begin as soon as possible after the IFSP meeting), and the anticipated duration of those services. The service coordinator manual directs the Service Coordinator (SC) to include the following: "When will we start? How often? How long? Where will it be done? – Enter actual start date of service. Enter how many times a week service will be provided. Enter how many minutes each session will last. Enter where service will be provided." The Service Provider Report includes this information as well. Attempting to quantify "timely" for the reporting requirement of the Improvement Plan, we identified a need to define timely provision of services, to train on service delivery practices and models, and to address the appropriate use of multidisciplinary and transdisciplinary teams for evaluation/assessment, IFSP development, and service delivery.

4. Locating service providers willing to serve infants and toddlers in natural settings is a challenge in several health districts.

5. In areas where individual providers conduct discipline-specific evaluations, write discipline-specific reports, and make discipline-specific recommendations in isolation from other team members, there is not a true team approach that looks at children and families holistically.

   Resulting problems include:

   a. Recommending discipline-specific services that are not integrated and coordinated;

   b. Failure to write goals and outcomes or to identify all supports and services necessary to enhance the family's capacity to meet the developmental needs of the infant or toddler;

   c. Offering services to families in other settings when natural settings are appropriate and available. Many providers use a medical model for evaluations and service provision and

provide child-centered, direct therapies versus family-centered services that incorporate routines to achieve functional outcomes. Some of our current services address each area of development in isolation from other services (multidisciplinary vs. transdisciplinary);

d. Scheduling services when and how often the provider is available, or as dictated by Medicaid billing allowances, rather than as indicated on the IFSP and in consideration of the children/families' priorities, resources, concerns, and routines; and

e. Creating a waiting list for therapy rather than referring to other providers.

6. Many agencies serving multiple health districts/counties do not offer a variety of services in each of the geographic regions they serve.

7. Medicaid Issues:

   a. Waiting for the Treatment Authorization Number (TAN) from Medicaid delays the initial provision of services or continuation of services for some infants and toddlers.

   b. Medicaid Policies do not allow for multiple providers in a coaching/consultation model to bill for each visit. This affects use of coaching, consultation, and other teaming activities.

   c. Travel (time or mileage) is not reimbursed.

   d. Medicaid determines eligibility for reimbursement on "medical necessity" and rehabilitation vs. developmental appropriateness.

8. Hospitalizations (e.g., NICU), illness and family scheduling issues impact timely provision of initial services. The stakeholder input on October 25-26, 2005, included the need to identify examples of acceptable justifications for delays and to develop a method for qualifying and quantifying justifications in FSIS.

9. Use of a Primary Service Provider (PSP) as coach model, when appropriate to meet the infant or toddler's (and family's) unique needs, has been a topic in training and is used in some districts. Its use has been limited in most of the health districts. The PSP as coach model focuses on coaching of the identified learners as the primary intervention strategy to implement jointly-developed, functional, discipline-free IFSP outcomes in natural settings with ongoing coaching and support from other team members. The discipline of the chosen PSP(s) is based on the IFSP outcomes, relationships with the learners, and expertise in the areas of support needed by the learners. When implemented appropriately, the model has been well-accepted by families.

10. Indicators, including Child Find, timely provision of services, services in natural environments, 45-day timelines, and accurate and timely data, are being monitored and reported on the monthly Progress Report Card. Statewide improvements were noted for July through November 2005 with some slippage in December.

Baseline Data for FFY 2004 (2004-2005):

Of the 1213 initial IFSPs developed in FFY 2004 (2004-2005), 877 (72%) received their first service in thirty days or less; 336 (28%) received their first service in more than 30 days. All data reported for this indicator were obtained from the FSIS database.

Discussion of Baseline Data:

FFY 2004-2005 data used for the baseline are for timely provision of the first service initiated following initial IFSP development. In the past, the database was not configured to capture information about initiation of all services. The data system simply calculated how long it took for the initial service to begin. The data system has been changed, and since July 1, 2005, dates for initiation of all services are being captured.

The data from July 1-December 31, 2005, indicated that 83% of all services began in thirty days or less after development of the initial IFSP; 9% of services began in 31- 45 days; 3% of services began in 46-60 days; and 6% of services began after 60 days. The state did not have a definition

for "timely provision of services" before writing the SPP. The new definition of "timely provision of services" is "within 30 days of the projected initiation date as indicated on the IFSP."

Anecdotal reasons most frequently given for failure to initiate services in a timely manner are related to service provider availability. However, there is no field in the data system to enter justifications for this indicator. Therefore, for reporting purposes, justifications could not be quantified. For the data to be reported in February 2007, quantification will be accomplished by adding a field in the database to enter each justification and to qualify and quantify justifications for reporting purposes.

FFY	Measurable and Rigorous Targets for Indicator 1:
2005 (2005-2006)	**100%** of infants and toddlers with IFSPs will receive the early intervention services on their IFSPs in a timely manner.
2006 (2006-2007)	**100%** of infants and toddlers with IFSPs will receive early intervention services on their IFSPs in a timely manner.
2007 (2007-2008)	**100%** of infants and toddlers with IFSPs will receive the early intervention services on their IFSPs in a timely manner.
2008 (2008-2009)	**100%** of infants and toddlers with IFSPs will receive the early intervention services on their IFSPs in a timely manner.
2009 (2009-2010)	**100%** of infants and toddlers with IFSPs will receive the early intervention services on their IFSPs in a timely manner.
2010 (2010-2011)	**100%** of infants and toddlers with IFSPs will receive the early intervention services on their IFSPs in a timely manner.

Improvement Activities/Timelines/Resources:

Activities to commence in the second half of FFY 2005 (2005-2006)

1. Require the use of this definition of timely provision of services statewide: "Services will begin within 30 days of the IFSP meeting date (initial or revision) unless a later initiation date is specified on the IFSP."
    a. If a later date is specified,
        i) It cannot be for the primary service(s);
        ii) The reason(s) for the later date(s) must be stated in writing; and
        iii) The reason(s) for the later date(s) must be based on the child and family's unique needs (e.g. bi-annual hearing follow-ups for children with hearing impairments).
    b. The additional service(s) with a later initiation date(s) must begin within 30 days of the initiation date(s) specified on the IFSP for the specific service(s).

2. Add fields in the data system to:
    a. Capture justifications and
    b. Qualify each justification (e.g. family reasons, provider reasons, MDH staff reasons), which will aid in quantification and program management and improvement.
    c. Capture information about timely provision of services following IFSP revision.
3. Determine eligibility, write an IFSP, and begin service coordination for families of infants in the Neonatal Intensive Care Unit (NICU) while the infant is still hospitalized. First Steps has a contract with the University of Mississippi Medical Center (UMC) to provide services to hospitalized infants and toddlers. At Forrest General Hospital (FGH) in Hattiesburg, a Service Coordinator is being assigned to work with families and developmental/educational personnel employed by USM/IDS who provide services to babies in the FGH NICU.
4. Explore options for addressing financial issues (e.g. using the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program within Medicaid to fund EI services for Medicaid recipients).
5. Enter into contracts and create salaried positions [with state and federal funds and revenue generated from Medicaid through Targeted Case Management (TCM)] to staff early intervention teams in every district. Collaborate with other agencies and utilize providers with the necessary expertise to develop early intervention teams that will:
    a. Conduct comprehensive multidisciplinary evaluations and assessments, including measuring outcomes;
    b. Serve on IFSP teams;
    c. Provide technical assistance and training to Department of Health EI staff and other providers;
    d. Provide coaching and consultation to families and providers;
    e. Provide other EI services in natural settings and in a timely manner when other providers are unavailable; and
    f. Monitor their districts on an ongoing basis and other districts during focus monitoring activities.
6. Improve services to infants/toddlers and their families by:
    a. Providing service coordinators with training and materials to enable them to:
        i) Explain the benefits of services in natural settings to parents and service providers;
        ii) Conduct family assessments that lead to writing effective outcome statements considering priorities, resources, concerns, and routines; and
        iii) Advocate for the infants, toddlers, and families they serve.
    b. Presenting research to referral sources and providers on the benefits of implementing family-centered services in natural settings incorporating routines.
7. Provide training on:
    a. The State's definition of "timely provision of services" and activities to achieve the goal,
    b. Service delivery models incorporating best practices that support the provision of early intervention services in natural settings, and
    c. Minimum Standards and best practices for Service Coordination.
8. Add "alerts" in the First Steps Information System (FSIS) to remind Service Coordinators (SC) of

service initiation timelines.

9. Implement a Primary Service Provider (PSP) as coach model when appropriate to meet the unique needs of the child and family that will lead to timely provision of services, emphasize relationships, empower families to help their children learn and develop, and improve outcomes.
10. Utilize national resources for technical assistance (including OSEP, NECTAC and SERRC) to arrange for high quality training within the state to address the best practice issues.
11. Utilize stakeholders with expertise in each of the above areas to provide training and technical assistance to other stakeholders.
12. Recruit and retain providers who provide services in natural settings.
13. Continue to issue the Progress Report Card related to the Improvement Plan. Work with districts in reviewing their District Work Plans, revising goals, planning and carrying out activities and strategies, identifying resources, and holding people accountable.

Activities to commence in FFY 2006 (2006-2007)

1. Continue the changes made in the second half of FFY 2005.
2. Evaluate the effectiveness of the above activities and make necessary changes. Utilize broad stakeholder input in this process.
3. Contract with providers willing to implement activities of the SPP and State/District Improvement Plans.
4. Provide training:
    a. On the new requirements of IDEA'04 and
    b. To new EI team members on a continual basis to increase the number of effective and efficient teams, addressing inevitable turnover of staff and new findings regarding best practices.
5. Begin revision of the policies and procedures to address changes in IDEA'04 utilizing broad stakeholder input.
6. The Service Coordinator manual and necessary forms will be revised to support the changes.

Activities to commence in FFY 2007 (2007-2008), 2008 (2008-2009) and in FFY 2009 (2009-2010)

1. Evaluate the effectiveness of the above activities and make necessary changes. Utilize broad stakeholder input in this process.
2. Provide training to address compliance and/or performance issues identified in the Annual Performance Reports and through monitoring activities. This training will be ongoing within each health district through coaching, mentoring, and embedded training/technical assistance.

Activities to commence in FFY 2010 (2010-2011)

Evaluate the effectiveness of the above activities in meeting the SPP goals and make necessary changes. Utilize broad stakeholder input in this process.

Resources for Activities and Persons Responsible/Accountable

1. Database: C.O. staff, data manager, and FSIS User Group
2. Policy and procedural changes and forms: C.O staff with broad stakeholder input
3. Annual Performance Reporting requirements: C.O. staff, district staff, database, general supervision system including monitoring information, and broad stakeholder input
4. Training and Technical Assistance: C.O. staff, district staff, Early Intervention teams, collaborative efforts with DMH and MDE, national resources [e.g. OSEP, NECTAC, SERRC, Infants/Toddlers Coordinators Association (ITCA), Westat], stakeholders with special expertise, Comprehensive System of Personnel Development (CSPD) Committee members, university training programs, Early Intervention Conference, personnel funded through grants, First Steps Resource Library
5. Monitoring: C.O. staff, Quality Monitors, EI teams, MDH and DMH staff, Parent Advisors, Medicaid, and other stakeholders
6. Early Intervention Teams: personnel will be funded through contracts; collaborative agreements with Part B, Department of Mental Health and other private or public agencies; Part C salaried staff; university programs, training personnel, and practicum students
7. Collaboration: administrative personnel from agencies providing EI services
8. Publicity and Child Find: C.O. staff, MDH staff from the Office of Communications, DCs and SCs
9. Funding sources: state, Part C, and third-party payments; grant monies (e.g. EHDI-M, GSEG); and revenue generated by MDH

Monitoring Priority: Early Intervention Services In Natural Environments

Indicator 2: Percent of infants and toddlers with IFSPs who primarily receive early intervention services in the home or programs for typically developing children.

Measurement:
Percent = # of infants and toddlers with IFSPs who primarily receive early intervention services in the home or programs for typically developing children divided by the total # of infants and toddlers with IFSPs times 100.

Overview of Issue/Description of System or Process:

1. Current efforts include increasing awareness of the benefits of providing services in the natural environment. Training includes an emphasis on the requirement that early intervention services be provided in natural settings (e.g., the home, child care centers, or other community settings) to the maximum extent appropriate to meet the needs of the child, and on the requirement to provide a justification for services outside the natural environment. Other training includes proper use of different service delivery models such as a Primary Service Provider (PSP) as coach model.

2. Many district staff members have some knowledge of the benefits of providing services in natural settings. Most of these staff members are not comfortable explaining the benefits or legal requirements of natural environment provisions. Enhancing knowledge of all stakeholders and providers should decrease the perception that more services in a clinic are better.

3. The "Step by Step Process of Service Coordination" in our service coordinator manual requires discussing natural environments concept with parents but describes a process more supportive of services provided under a medical model. Parent choice of services is stressed without providing parents with the information needed to make informed choices (i.e., family centered and integrated approaches to address their child's developmental needs).

4. The format used to document service provision (except where the new process has been piloted) does not encourage writing IFSP outcomes to be achieved through natural routines for the infant/toddler and family. In districts VIII and IX, use of a "bubble sheet" emphasizes routines and outcomes in the development of IFSPs. At the December 2005 stakeholders' meeting, a bubble sheet activity was included, with Districts VIII and IX and DMH staff serving as leaders for mock IFSP teams.

5. Team members are unable to identify and write adequate child outcome-based justifications for services outside natural settings. At the December 2005 stakeholders' meeting, the framework for a guiding document was begun.

6. The categories used for natural environment in the FSIS were not clearly defined. Some categories for natural environment did not meet the federal definition of natural environment. Typically since July 1, 2005, categories selected included home, typical, designed, or service provider. "Other" requires a description to determine if it meets the definition for natural environment. Ongoing training and technical assistance regarding natural environments has been provided.

7. Finding service providers willing to serve infants and toddlers in natural environments is a challenge in several health districts.

    a. In areas where individual providers conduct their evaluations and make discipline-specific recommendations, there is no true team process. Please refer to Indicator 1, overview # 5.

    b. Many agencies serving multiple health districts do not offer a variety of services in each of the districts they serve.

    c. In some counties, only special instruction is available in NE. All other services are provided at hospitals and clinics.

    d. Providers who were unable or unwilling to provide services in the NE have been encouraged to use existing resources in NE or to create programs with typically developing children. The University of Mississippi is piloting a program for Speech/Language and Audiology students to have practicum experiences in NE and to create a typical program in their clinic. These practices have been suggested to other university training programs. Small grants are offered to offset travel expenses. CSPD committee members have been assigned to work with major university training personnel to promote these ideas.

8. Medicaid Issues:
    a. Medicaid does not reimburse the provider for travel (mileage or time).
    b. Please refer to Indicator 1, overview # 7 (a, c, and d).
9. Hospitalized infants and toddlers are put in tracking until they are discharged from the hospital.
10. Use of a Primary Service Provider (PSP) as coach model, when appropriate to meet the infant or toddler's (and family's) unique needs, has been a topic in training and is used in some districts. Its use has been limited in most of the health districts; when used appropriately it has been well-accepted by families. Please refer to Indicator 1, Overview # 9 for more details.

Baseline Data for FFY 2004 (2004-2005):

In FFY 2004 of the 1249 infants and toddlers who were initially referred and had initial IFSPs developed and who received early intervention services, 1028 (82%) received early intervention services primarily in the home or community settings with typically developing peers. Although the 618 data were available for reporting on the Child Find indicators, the Natural Environment data are not yet available. Data were obtained from the FSIS database for FFY 2004.

Discussion of Baseline Data:

Provision of services in home and community settings with typically developing peers has increased while provision of services in clinics, hospitals, design programs or other service provider settings has continued to decrease in the State. Targets were set by considering the FFY 2004 (2004-2005) data as well as the monthly Report Card data. The data from July 1, 2005-December 31, 2005, indicate that 92% of the infants and toddlers with IFSPs received early intervention services primarily in the NE. Data were obtained from the FSIS database. Reasons for services outside NE tend to be based on family choice, service provider availability, and the need for special equipment available only in a clinical setting.

FFY	Measurable and Rigorous Targets for Indicator 2:
2005 **(2005-2006)**	**93%** of infants and toddlers with IFSPs will receive early intervention services primarily in the home or programs for typically developing children with **100%** child outcome-based justifications for remaining **7%**.
2006 **(2006-2007)**	**94%** of infants and toddlers with IFSPs will receive early intervention services primarily in the home or programs for typically developing children with **100%** child outcome-based justifications for remaining **6%.**
2007 **(2007-2008)**	**95%** of infants and toddlers with IFSPs will receive early intervention services primarily in the home or programs for typically developing children with **100%** child outcome-based justifications for remaining **5%.**
2008 **(2008-2009)**	**96%** of infants and toddlers with IFSPs will receive early intervention services primarily in the home or programs for typically developing children with **100%** child outcome-based justifications for remaining **4%**.
2009 **(2009-2010)**	**97%** of infants and toddlers with IFSPs will receive early intervention services primarily in the home or programs for typically developing children with **100%** child outcome-based justifications for remaining **3%**.
2010 **(2010-2011)**	**98%** of infants and toddlers with IFSPs will receive early intervention services primarily in the home or programs for typically developing children with **100%** child outcome-based justification for remaining **2%.**

Improvement Activities/Timelines/Resources:

Activities to commence in the second half of FFY 2005 (2005-2006)

1. Clearly define the categories in FSIS used to report natural environment (i.e., natural environment = home or community, and other = any other setting). Change the FSIS field to reflect the federal definition.
2. Provide guiding questions to determine whether the decision to provide a service outside natural environments ("other" in the database) meets the criteria for a child outcome-based justification. Document decisions in FSIS and on the guiding document to be attached to the IFSP.
3. Add fields in the database to indicate that the justification has been reviewed and appropriately qualified by an administrator.
4. Please refer to Indicator 1, **Activities to commence in the second half of FFY 2005**, activities 3, 4, 5, 9, and 13 .
5. Explain the new monitoring process to service providers with emphasis on the following:
    a. Monitoring activities will be used to identify Program Improvement activities to meet the required targets for the State Performance Plan.
    b. Monitoring findings and the resulting Improvement Plans at both the state and local levels will be published.

c. To meet targets of the SPP, the Improvement Plans for districts and providers will include district goals, training and technical assistance needs, available resources, activities and strategies, and responsible parties.

6. Please refer to Indicator 1, **Activities to commence in the second half of FFY 2005,** Activity 6.
7. Provide training on:
    a. Natural environment definition, benefits, and best practices;
    b. Determining whether the decision to provide services outside natural environments meets the criteria for a child outcome-based justification;
    c. Service delivery models incorporating best practices that support the provision of early intervention services in natural settings;
    d. IFSP development incorporating routines to achieve functional outcomes;
    e. Cultural diversity; and
    f. Service Coordination.
8. Make changes in the Service Coordinator's Manual to guide personnel in offering more effective services.

Activities to commence in FFY 2006 (2006-2007)

Please refer to the activities for Indicator 1.

Activities to commence in FFY 2007 (2007-2008), 2008 (2008-2009) and in FFY 2009 (2009- 2010)

Please refer to the activities for Indicator 1.

Activities to commence in FFY 2010 (2010-2011)

Please refer to the activities for Indicator 1.

Resources for Activities

Please refer to the resources for Indicator 1, unless otherwise specified.

Monitoring Priority: Early Intervention Services In Natural Environments

Indicator 3: Percent of infants and toddlers with IFSPs who demonstrate improved:

A. Positive social-emotional skills (including social relationships);

B. Acquisition and use of knowledge and skills (including early language/communication); and

C. Use of appropriate behaviors to meet their needs.

(20 USC 1416(a)(3)(A) and 1442)

Measurement:

A. Positive social-emotional skills (including social relationships):

a. Percent of infants and toddlers who reach or maintain functioning at a level comparable to same-aged peers = # of infants and toddlers who reach or maintain functioning at a level comparable to same-aged peers divided by # of infants and toddlers with IFSPs assessed times 100.
b. Percent of infants and toddlers who improve functioning = # of infants and toddlers who improved functioning divided by # of infants and toddlers with IFSPs assessed times 100.
c. Percent of infants and toddlers who did not improve functioning = # of infants and toddlers who did not improve functioning divided by # of infants and toddlers with IFSPs assessed times 100.

If children meet the criteria for a, report them in a. Do not include children reported in a in b or c. If a + b + c does not sum to 100%, explain the difference**.**

B. Acquisition and use of knowledge and skills (including early language/communication):

a. Percent of infants and toddlers who reach or maintain functioning at a level comparable to same-aged peers = # of infants and toddlers who reach or maintain functioning at a level comparable to same-aged peers divided by # of infants and toddlers with IFSPs assessed times 100.
b. Percent of infants and toddlers who improved functioning = # of infants and toddlers who improved functioning divided by # of infants and toddlers with IFSPs assessed times 100.
c. Percent of infants and toddlers who did not improve functioning = # of infants and toddlers who did not improve functioning divided by # of infants and toddlers with IFSPs assessed times 100.

If children meet the criteria for a, report them in a. Do not include children reported in a in b or c. If a + b + c does not sum to 100%, explain the difference**.**

C. Use of appropriate behaviors to meet their needs:

a. Percent of infants and toddlers who reach or maintain functioning at a level comparable to same-aged peers = # of infants and toddlers who reach or maintain functioning at a level comparable to same-aged peers divided by # of infants and toddlers with IFSPs assessed times 100.
b. Percent of infants and toddlers who improved functioning = # of infants and toddlers who improved functioning divided by # of infants and toddlers with IFSPs assessed times 100.
c. Percent of infants and toddlers who did not improve functioning = # of infants and toddlers who did not improve functioning divided by # of infants and toddlers with IFSPs assessed times 100.

If children meet the criteria for a, report them in a. Do not include children reported in a in b or c. If a + b + c does not sum to 100%, explain the difference**.**

Description of the Outcome Measurement System for Mississippi:

In the First Steps Early Intervention Program, evaluations and assessments are most frequently completed by teams comprised of two or more of the following: speech/language pathologists, physical therapists, occupational therapists, and/or early interventionists, all of whom meet applicable state licensure and/or personnel qualifications. The composition of the team is based on the unique needs of the child and family. The evaluation team must use more than one procedure to determine eligibility (e.g. standardized and less formal measures to include play-based assessment, interview, review of records, and observation across settings and people).

Instruments are chosen to assess the unique needs of the child and family with research-based procedures and protocols and identify services appropriate to meet those needs. Conclusions and informed clinical opinion are based on several sources of information. Initial evaluation teams provide developmental ages and percentage of delay, if applicable, and list strengths in the specific areas: physical (including vision and hearing), cognitive, social or emotional, communication, and adaptive.

Progress toward goals has been recorded in individual child records but has not been captured in the First Steps Information System (FSIS). Data fields will be added to the FSIS for collection and entry of all child outcome data elements.

Description of Measurement Strategies Mississippi will use:

The stakeholder group which met on October 25-26, 2005, recommended using the Early Childhood Outcomes Center Child Outcomes Summary Form to summarize outcome data from multiple sources.

Who will be included in the measurement?
Every child enrolled in First Steps will be included in the measurement of child outcomes. Baseline Data for FFY 2006 (2006-2007) will be gathered on all children with an IFSP during the reporting interval.

What tool(s) will be used?
Mississippi's Part C system will summarize child outcome information for every child using the Early Childhood Outcomes Center Child Outcomes Summary Form: 7-point version. Local programs will choose the measurement tools for conducting assessments and evaluations considering both Part B and Part C guidelines for selecting appropriate tools. The most commonly used tools include the Infant-Toddler Developmental Assessment (IDA); the Carolina Curriculum for Infants and Toddlers with Special Needs, Second Edition (CCITSN) Assessment Tool, The Carolina Curricula: The Carolina Curriculum for Preschoolers with Special Needs (CCPSN) Assessment Tool; Early Learning Accomplishment Profile (ELAP), Battelle Developmental Inventory, Second Edition (BDI-2); and the Developmental Profile II (DP II).

How will the tool be completed? By whom? When?
Entry Data: Within the first 45 days from initial referral to First Steps, the first measurement will occur with every eligible child. The measurement tools chosen for entry and exit data will meet IDEA guidelines for conducting assessments and evaluations and for selecting instruments. Assessment guidelines under IDEA'04 are as follow:

1. No single measure or assessment shall be used as the sole criterion for determining whether a child is a child with a disability or determining an appropriate educational program for the child.

2. Technically sound instruments that may assess the relative contribution of cognitive and behavioral factors, in addition to physical or developmental factors will be used.

3. Assessments and other evaluation materials used

    a. are selected and administered so as not to be discriminatory on a racial or cultural basis;

    b. are provided and administered in the language and form most likely to yield accurate information on what the child knows and can do academically, developmentally, and functionally, unless it is not feasible to so provide or administer;

    c. are used for purposes for which the assessments or measures are valid and reliable;

    d. are administered by trained and knowledgeable personnel; and

    e. are administered in accordance with any instructions provided by the producer of such assessments.

4. The child is assessed in all areas of suspected disability.

5. The instruments chosen must allow an assessment of the unique needs of the child in terms of each of the above developmental areas (i.e., physical including vision and hearing; cognitive; social or emotional; communication; and adaptive), including the identification of services appropriate to meet those needs.

6. Assessment tools and strategies that provide relevant information that directly assists persons in determining the educational needs of the child are provided.

7. Any adaptations (e.g., for motor or sensory issues) will be described in the eligibility/assessment report.

The early intervention team conducting the comprehensive multidisciplinary evaluation and assessment will complete the Child Outcomes Summary form during the documentation of eligibility, prior to the initial IFSP meeting. The information compiled on the form will be reviewed by the IFSP team at each IFSP meeting. Data will be submitted and entered at the health district level.

Annual Data: The IFSP team will complete the Child Outcomes Summary form at each IFSP review/revision and reference the documentation used to support the ratings. The IFSP must be evaluated and revised annually and periodic reviews must be conducted at least every six months (or sooner if requested by the family or as the infant/toddler's needs change). Data will be entered into the FSIS at the health district level.

Exit Data: The standardized assessment instrument(s) used to determine the presence of a disability will be readministered six (6) months prior to transition or when a child is determined to no longer need early intervention services. The measurement tools chosen for the entry and exit data will meet IDEA guidelines for selecting assessment and evaluation instruments. First Steps will collaborate with the Mississippi Department of Education to encourage inclusion of a local school district Multidisciplinary Evaluation Eligibility Team (MEET) member on the early intervention team conducting the comprehensive multidisciplinary evaluation and assessment to ensure the timely determination of Part B eligibility. Data will be submitted and entered at the health district level.

Who will report data to whom, in what form and how often?
Data will be collected locally and entered at each district office in the FSIS. Aggregate data reports will be generated quarterly. Data will be reported to OSEP annually in the Annual Performance Report. Reports to OSEP will include data from children who were enrolled for more than six (6) months in First Steps.

Child outcome data for children referred to First Steps after 30 months of age or who receive early intervention for less than six months will not be included in the data reported to OSEP, but may be used to satisfy additional in-state reporting requirements and for monitoring and program improvement activities.

What are the timelines for implementation of data collection and reporting?
Mississippi's initial baseline data collection will occur between March 1, 2006, and September 30, 2006. Ongoing data collection will continue from October 1, 2006, forward. Baseline entry data from March 1, 2006 – September 30, 2006, will be reported to OSEP in the Annual Performance Report due in February 2007. In addition, the Annual Performance Report due in February 2007 will include measurable and rigorous targets, improvement strategies, timelines and resources related to Indicator #3. Exit data will be collected on all children enrolled between March 1, 2006 and September 30, 2006, and exiting between October 1, 2006, and June 30, 2007, for reporting to OSEP in the Annual Performance Report due in February 2008.

Description of Sampling Methodology (if applicable):

Not applicable. Mississippi's Part C system will not use sampling to collect data for Indicator #3.

Activities to commence in the second half of FFY 2005 (2005-2006)

1. Provide training and technical assistance on the purpose of including this indicator and the activities required to address it.
2. Data fields will be added to the FSIS for collection and entry of all child outcome data elements.
3. Determine whether a General Supervision Enhancement Grant (GSEG) was awarded to aid Mississippi in addressing this indicator. If so, implement the activities outlined by the GSEG grant.
4. First Steps will collaborate with the Mississippi Department of Education to encourage inclusion of a local school district Multidisciplinary Evaluation Eligibility Team (MEET) member on the early intervention team conducting the comprehensive multidisciplinary evaluation and assessment to ensure the timely determination of Part B eligibility.
5. Please refer to Indicator 1, Activity 5, related to developing early intervention teams.
6. Please refer to the training activities for Indicators 1 and 2.

Resources for Activities

Please refer to the resources for Indicator 1, unless otherwise specified.

Monitoring Priority: Early Intervention Services In Natural Environments

Indicator 4: Percent of families participating in Part C who report that early intervention services have helped the family:

A. Know their rights;
B. Effectively communicate their children's needs; and
C. Help their children develop and learn.

(20 USC 1416(a)(3)(A) and 1442)

Measurement:

A. Percent = # of respondent families participating in Part C who report that early intervention services have helped the family know their rights divided by the # of respondent families participating in Part C times 100.

B. Percent = # of respondent families participating in Part C who report that early intervention services have helped the family effectively communicate their children's needs divided by the # of respondent families participating in Part C times 100.

C. Percent = # of respondent families participating in Part C who report that early intervention services have helped the family help their children develop and learn divided by the # of respondent families participating in Part C times 100.

Overview of the System:

First Steps is a program that matches the unique needs of infants and toddlers who have developmental delays with the professional resources available within the community system. Information about family concerns, priorities, and resources is obtained during the initial interview (intake) with the family using the developmental history and family assessment. Families are asked to identify their child's routines, likes, and dislikes; the family's preferred activities; family supports; and siblings' needs. The service coordinator must complete the family assessment form with the family's consent during the intake. The information recorded must be written in a manner that is acceptable to the family for sharing with other early intervention providers. The service coordinator records the family's concerns, priorities, resources and routines in Section Two of the IFSP during the intake process.

The Family Rights pamphlet is presented to all families at the time of initial intake and with every Written Prior Notice (WPN). A WPN is required when there is a scheduled appointment; an evaluation; an IFSP meeting (including any reviews or annual updates)**;** a transition meeting; a change of agency providing a service; a change of service coordinators; or a change of the child's goals, frequency, duration, or place of service. Families must have multiple opportunities to be informed of their rights. During the intake process, the service coordinator explains the two-page Family Rights summary to the parents. A copy of the detailed Family Rights brochure, including a glossary of terms, is given to the parents. The Family Rights summary mentions the means by which to file a complaint (including the toll-free # at the First Steps central office) but does not cover the other available remedies (i.e., mediation and due process hearings). Parents are given the Part B Procedural Safeguards at the transition meeting.

Service coordinators and service providers are trained and oriented to family-centered practices and infant/toddler and family rights under Part C of the Individuals with Disabilities Education Act through training opportunities available through the University of Southern Mississippi/Institute for Disability

Studies and WilloTEAM. District monitoring processes include review of the required forms completed in the case file and documentation of dissemination of the Family Rights pamphlet as required.

The First Steps stakeholder group and additional stakeholders recommended the following activities:

1. Use the Early Childhood Outcomes Center Family Outcomes Survey or a similar survey.
2. Revise the two-page Family Right summary to address mediation and due process hearings.
3. Give families the revised Family Rights Summary. Explain their rights and give them the opportunity to ask questions.
4. Revise the Policies and Procedures, the Family Rights pamphlet, and the Family Rights summary to address changes in IDEA'04.
5. Maintain consistency statewide in the packets given to parents. Give parents the following:
    a. an ABC process for parents to advocate for their child;
    b. a description of the responsibilities of all personnel involved in service delivery;
    c. the state toll-free number; and
    d. a description of mediation and due process hearing procedures (including who to call and where to write to request relief).
6. Clearly define terms used in the provision of EI services.
7. Make all information accessible to all parents (e.g. Braille, written or spoken in the primary language spoken by the parent/guardian, in a format accessible to text readers, an audio file, or sign language).
8. Give parents a document for making informal complaints, written signed complaints, requests for mediation, and requests for due process hearings.

Description of Measurement Strategies Mississippi will use:

Mississippi's Part C system will attempt to collect information from every family transitioning from First Steps using the Early Childhood Outcomes Center Family Outcomes Survey. The tool will be presented to each family within 30 days of enrollment for baseline data and within 30 days of the child's transition to preschool and other appropriate community services to measure outcomes. The survey will be presented to families by parent advisors or other trained non-district personnel as a hard copy in English or Spanish, or presented verbally if needed in another language or via other primary modes of communication (e.g., interpreter) described above. Families will have the option of completing the survey with the parent advisor or independently. The survey will be returned to the First Steps central office in a stamped/self-addressed envelope. Data entry will be accomplished through a scanning process. Future considerations will include ~~c~~ontracting with an outside entity to distribute the surveys in a manner accessible to all our parents, and to collect and analyze applicable data.

The Family Outcomes Survey will be presented to every family whose child or children were enrolled in First Steps during the federal fiscal year. Data will be reported to OSEP only from surveys completed by families whose children were enrolled for more than six (6) months in First Steps. Survey results from families of children referred to First Steps after 30 months of age or who receive early intervention for less than six months will not be included in the data reported to OSEP, although the data may be used to satisfy other in-state reporting requirements and for monitoring and program improvement activities.

Activities to commence in the second half of FFY 2005 (2005-2006)

1. Provide training and technical assistance on:
    a. the purpose of collecting this information;
    b. Parental Rights (for district personnel, service providers, parents and other stakeholders);
    c. effective service coordination, IFSP development and provision of services to families; and
    d. appropriate practices that are responsive to diverse cultures.
2. Revise the two-page Family Right summary to include mediation and due process hearing procedures.
3. Revise the Policies and Procedures, the Family Rights pamphlet, and the Family Rights summary to address changes in IDEA'04.
4. Maintain consistency statewide in the packets given to parents. Include the following:
    a. an ABC process for parents to advocate for their child;
    b. a description of the responsibilities of all personnel involved in service delivery;
    c. the state toll-free number; and
    d. a description of mediation and due process hearing procedures (including who to call and where to write).
5. Clearly define all terms contained in parent information materials.
6. Make all information accessible to all parents (e.g. Braille, written or spoken in the primary language spoken by the parent/guardian, in a format accessible to text readers, an audio file, or sign language).
7. Revise the FSIS to include data fields for collection and entry of family outcome data elements. The results of individual surveys will not be accessible at the district level. The revisions will include built-in verification and edit functions to prevent avoidable errors.
8. Facilitate gathering of the family outcome data by:
    a. Distributing the survey through parent advisors or other trained non-district personnel and using a stamped/self-addressed envelope to return the survey to the First Steps Central office to allay fears that negative ratings will affect services.
    b. Generating quarterly reports to indicate the number of parents of children within 30 days of transition selecting each potential rating for the five family outcomes. Number of families responding will be compared to number of children who transition from the First Steps system during the same period of time to ensure appropriate implementation and application of this new data collection requirement.
    c. Making quality assurance calls to districts with low numbers of responses to the Family Outcomes Survey relative to numbers of transitioning children. The purpose of the calls will be to determine reasons for low response rates.
    d. Providing technical assistance and support as appropriate to address any identified areas of need within district programs.
    e. Assigning unique ID numbers to each child for purposes of this survey. The number will be placed on both the pre- and post- surveys to allow for the tabulation of the difference between initial and end results. This information will be used to determine training needs.

f. Collecting the data used for this indicator in a manner that protects the respondent's identity. This will allow the parent/guardian to respond without concern for how the responses may impact relationships with the service coordinator and other service providers.

9. Create and distribute a single document for making informal complaints, written signed complaints, requests for mediation, and requests for due process hearings.

Resources for Activities

Please refer to the resources for Indicator 1, unless otherwise specified.

Description of Measurement Strategies Mississippi will use:

Who will be included in the measurement?
Every family whose child or children were enrolled in First Steps during the applicable federal fiscal year will be strongly encouraged to participate in the measurement of family outcomes.

What tool(s) will be used?
Mississippi's Part C system will attempt to collect information from every family enrolled in First Steps during the applicable federal fiscal year using the Early Childhood Outcomes Center Family Outcomes Survey.

How will the tool be presented to families? By whom?
The survey will be presented to families by a parent advisor or non-district personnel trained in the presentation and use of the tool. The survey will be presented in the format needed by the parent/guardian (e.g. Braille, written or spoken in the primary language spoken by the parent/guardian, in a format accessible to text readers, an audio file, or sign language). The person presenting the survey will explain how the participant's confidentiality will be protected to allow the participant to provide the requested information without any fear of repercussions. Results of this survey will be reported at a district and state level in a manner which protects the confidentiality of the respondents.

When will the measurement occur?
Measurement will occur with each family within 30 days of the time of enrollment and within 30 days of the child's transition to preschool or other appropriate community services. Service coordinators will receive training on assessing families' priorities, resources, concerns, and routines so that the family outcomes can be addressed in IFSP development and service provision.

Who will report data to whom, in what form, and how often?
Data will be collected by the parent advisors and/or returned directly to the First Steps Central Office in stamped/self-addressed envelopes. Aggregate data reports will be generated quarterly. Data will be reported to OSEP annually in the Annual Performance Report. Reports to OSEP will include data from surveys completed by families whose children were enrolled for more than six (6) months in First Steps. Survey results from families of children referred to First Steps after 30 months of age or who receive early intervention for less than six months will not be included in the data reported to OSEP but may be used to satisfy other in-state reporting requirements and for monitoring and program improvement activities.

What are the timelines for implementation of data collection and reporting?
Mississippi's initial baseline data collection will occur between March 1, 2006, and September 30, 2006. Ongoing data collection will continue from October 1, 2006, forward. Baseline data, measurable and rigorous targets, improvement strategies, timelines, and resources will be reported to OSEP in the Annual Performance Report due in February 2007.

Description of Sampling Methodology (if applicable):
Not applicable. Mississippi's Part C system will not use sampling to collect data for Indicator #4.

Monitoring Priority: Effective General Supervision Part C / Child Find

Indicator 5: Percent of infants and toddlers birth to 1 with IFSPs compared to:

A. Other States with similar eligibility definitions; and

B. National data.

(20 USC 1416(a)(3)(B) and 1442)

Measurement:

A. Percent = # of infants and toddlers birth to 1 with IFSPs divided by the population of infants and toddlers birth to 1 times 100 compared to the same percent calculated for other States with similar (narrow, moderate or broad) eligibility definitions.

B. Percent = # of infants and toddlers birth to 1 with IFSPs divided by the population of infants and toddlers birth to 1 times 100 compared to National data.

Overview of Issue/Description of System or Process:

1. The DMH is the largest public provider of EI services in Mississippi. In the Spring of 2005, a pilot project between MDH and DMH was implemented in District IX. The goals were to eliminate redundant paperwork, to improve efficiency, and to maximize resources. On April 1, 2006, changes resulting from intense collaboration between the two agencies will be fully implemented. Child Find activities will be a unified effort within the state. The likelihood of children falling through the referral cracks will decrease. Four regional trainings on these changes will take place in January and February 2006, with IFSP training planned for March.

2. Zero to Three is implementing its program in Forrest County through the County and Youth Court system. Stakeholders serving children and families in Forrest County were invited to participate in the initial meeting at which Zero to Three staff presented the program. EI staff from District VIII and the Part C Coordinator participated in the meeting. Follow-up meetings will be scheduled throughout the coming year. Provisions of the ***Child Abuse Prevention and Treatment Act (****CAPTA)* and IDEA'04 were discussed during the meeting. EI staff expressed interest in collaborating with other agencies to implement the Zero to Three program through Judge McPhail's office. These collaborative efforts should increase referrals to First Steps and EI's ability to better meet the requirements of CAPTA and IDEA'04 for infants/toddlers exposed to abuse and neglect, and the effects of chemical abuse.

3. A unit in the First Steps Central Office (FS-CO) will be designated as the point of referral. Please refer to Indicator 14, **Activities to commence in the second half of FFY 2006**, Activity 2 for more information about the FS-CO central referral unit.

4. Some school districts in each of the nine health districts want to participate in the "transition pilot project," which began in Health District IX. By including Part B staff as multidisciplinary team members and ensuring that evaluations and assessments meet the guidelines for Part B and Part C, eligibility for Part B may be determined soon after the multidisciplinary evaluation/assessment takes place. This project is enhancing the quality of the multidisciplinary evaluations/assessments and is serving to increase awareness of early intervention eligibility criteria and services. The addition of each participating school district increases the number of multidisciplinary team

members and the likelihood of a timely and smooth transition.

5. Use of various terms to describe early intervention services (Part C, EI, First Steps, MDH, Infants/Toddlers program, Mental Health EIP) led to confusion over how to access the system. Currently referrals are received on the local level by First Steps and by the Department of Mental Health (DMH). A small number of referrals are sent directly to the First Steps Central Office. Some referral sources that provide services outside the EI system do not make referrals to First Steps. The agencies providing early intervention services are working to improve communication with and increase collaboration among referral sources and providers.

6. In 2005 new publicity and Child Find materials were developed and printed. New publications include a large poster with the English version on one side and Spanish on the other. Three versions of brochures were developed based on the child's age: 1-12 months, 13-24 months, and 25-36 months. Brochures are available in English, Spanish and Vietnamese. Developmental tear-off sheets are the most popular publications. The tear-off sheets are miniature versions of the poster. Trade show displays were distributed to District Coordinators. One trade show display was purchased for Central Office use. All materials are brightly colored with attractive pictures of babies depicting the activity referenced (crawling, walking, looking at books). The English version includes pictures depicting various ethnic backgrounds. The Spanish and Vietnamese versions include pictures of babies who reflect those cultures. Parent focus groups met to critique the old materials and to express their opinions regarding the development of new materials. The reading level is around fourth grade and includes more laymen's terms and less jargon than previous materials. Having brochures for each year of an infant/toddler's life came out of the parent focus group, as well. Materials are available at no charge for persons with a legitimate need. They will be distributed state-wide through providers, referral sources, and at professional meetings.

7. The number of teams available to conduct comprehensive evaluations and assessments is limited. Delays in evaluations lead to delays in services and reluctance of referral sources to refer infants and toddlers to First Steps. Use of a medical model for evaluations and service provision contributes to the delay. Conducting separate discipline-specific evaluations, writing individual reports, and developing IFSPs from multiple reports is more time consuming than using early intervention teams that conduct comprehensive multidisciplinary evaluations and assessments that facilitate writing IFSPs designed to achieve functional outcomes working in family routines.

8. Difficulty scheduling evaluations and finding service providers led to some service coordinator practices which hinder the process. Some service coordinators wait until after identified providers are available before scheduling the IFSP meeting.

9. Some hospitalized infants are put in tracking until they are discharged from the hospital.

10. While entering records in FSIS, some service coordinators made up ID numbers for infants and toddlers rather than using the SS#, Medicaid #, or phone #. When two children were assigned the same ID number, the database merged the records, reducing the numbers in the data system.

Baseline Data for FFY 2004 (2004-2005):

A. According to the December 1, 2004, Child Count (618 data), in Mississippi 0.74% of infants, birth to one, received services outlined on an IFSP, compared to states with similar eligibility criteria (broad, including at risk) whose average was 1.39%.

   According to the December 1, 2004, Child Count (618 data), in Mississippi 0.74% of infants, birth to one, received services outlined on an IFSP, compared to states with similar eligibility criteria (broad, excluding at risk) whose average was 0.90%.

According to the December 1, 2005, Child Count (618 data), in Mississippi 0.50% of infants, birth to one, received services outlined on an IFSP, compared to states with similar eligibility criteria (broad, including at risk) whose average was 1.39%.

According to the December 1, 2005, Child Count (618 data), in Mississippi 0.50% of infants, birth to one, received services outlined on an IFSP, compared to states with similar eligibility criteria (broad, excluding at risk) whose average was 0.90%.

B. According to the December 1, 2004, Child Count (618 data), in Mississippi 0.74% of infants, birth to one, received services outlined on an IFSP, compared to the national average of 0.92%, which excluded children at risk.

According to the December 1, 2005, Child Count (618 data), in Mississippi 0.50% of infants, birth to one, received services outlined on an IFSP, compared to the national average of 0.92%, which excluded children at risk.

Discussion of Baseline Data:

Mississippi is currently serving children birth to one year of age at a rate less than the national average and less than states with similar eligibility criteria. For this comparison, Mississippi used newly developed eligibility criteria rankings provided by OSEP based on the federal 618 Data tables submitted by states on December 1, 2004. Mississippi included our December 1, 2004 and 2005, 618 data since both were available at the time of submission of the SPP. The December 1, 2005, Child Count is considerably lower than the previous year. This drop can be accounted for by the relocation of families outside of Mississippi following Hurricane Katrina

Percentages served annually were calculated based upon the most current U.S. Census population estimates that are available with adjustments for annual state population growth. Comparisons to national percentages and states with similar eligibility criteria were based upon data excluding children at risk.

Although the Child Count raw data indicate that we were serving 207 infants birth to age one on December 1, 2005, during FFY2004 we served 884 infants who had an IFSP before their first birthday.

FFY	Measurable and Rigorous Targets for Indicator 5:
2005 (2005-2006)	**0.51%** of infants and toddlers birth to 1 will have IFSPs.
2006 (2006-2007)	**0.55%** of infants and toddlers birth to 1 will have IFSPs.
2007 (2007-2008)	**0.60%** of infants and toddlers birth to 1 will have IFSPs.

2008 **(2008-2009)**	**0.65%** of infants and toddlers birth to 1 will have IFSPs.
2009 **(2009-2010)**	**0.70%** of infants and toddlers birth to 1 will have IFSPs.
2010 **(2010-2011)**	**0.75%** of infants and toddlers birth to 1 will have IFSPs.

Improvement Activities/Timelines/Resources:

Activities to commence in the second half of FFY 2005 (2005-2006)

1. Create a central referral system at the First Steps Central Office to:
    a. Eliminate confusion over where or how to make referrals;
    b. Create and disperse a document depicting the "EI Umbrella;
    c. Increase the reliability of data;
    d. Assign a unique identifying number for each child to be generated automatically by the data system rather than created by service coordinators, eliminating problems with duplication of ID numbers;
    e. Slightly decrease the amount of time spent entering data at the district level; and
    f. Give central office staff a clearer picture of the number of referrals from various sources.
2. Collaborate more effectively with referral sources from both the state and local levels.
3. Collaborate with DMH, MDE, and with other departments within MDH to form model evaluation/assessment teams.
    a. These teams will use best practices when conducting evaluations/assessments.
    b. New team members will be trained on a continual basis.
    c. Teams will choose appropriate instruments and team members based on the needs identified prior to the multidisciplinary evaluation and assessment. If new problems are identified, further assessment will be conducted.
    d. Assessment team members will be trained to act as coaches/consultants.
4. Disseminate new Child Find materials published in 2005 during professional meetings/conferences, by visiting providers and referral sources, and through mass mail outs to referral sources with personal follow-up.
5. Work with the Communications Department at MDH to publicize the EI program through media, including newspapers, newsletters, website information, and their new radio talk show. A five minute radio spot was recorded to air on Public Radio in Mississippi.
6. Visit hospitals and NICUs to discuss processes and procedures for making referrals. Further develop relationships between First Steps and hospital personnel who have contact with infants and their families.

7. Attend health fairs, local and state conferences (e.g., Mississippi Chapter of the Academy of Pediatrics, Mississippi Association of Family Practitioners, Mississippi Nurses Association, Nurse Practioners), and meetings to set up trade show displays; to distribute brochures, developmental checklists and posters; and to answer questions regarding EI.
8. Provide training: Please refer to the training activities for Indicators 1 and 2.

Activities to commence in FFY 2006 (2006-2007)

Please refer to the activities for Indicator 1 and 2.

Activities to commence in FFY 2007 (2007-2008), 2008 (2008-2009) and in FFY 2009 (2009- 2010)

Please refer to the activities for Indicator 1.

Activities to commence in FFY 2010 (2010-2011)

Please refer to the activities for Indicator 1.

Resources for Activities

Please refer to the resources for Indicator 1, unless otherwise specified.

Monitoring Priority: Effective General Supervision Part C / Child Find

Indicator 6: Percent of infants and toddlers birth to 3 with IFSPs compared to:

A. Other States with similar eligibility definitions; and

B. National data.

(20 USC 1416(a)(3)(B) and 1442)

Measurement:

A. Percent = # of infants and toddlers birth to 3 with IFSPs divided by the population of infants and toddlers birth to 3 times 100 compared to the same percent calculated for other States with similar (narrow, moderate or broad) eligibility definitions.

B. Percent = # of infants and toddlers birth to 3 with IFSPs divided by the population of infants and toddlers birth to 3 times 100 compared to National data.

Overview of Issue/Description of System or Process:

Please refer to the overview for Indicator 5. Toddler will be added to any reference to infant in Indicator 5.

Baseline Data for FFY 2004 (2004-2005):

A. According to the December 1, 2004, Child Count (618 data), in Mississippi 1.69% of infants and toddlers, birth to three, received services outlined on an IFSP, compared to states with similar eligibility criteria (broad, including at risk) whose average was 2.74%.

According to the December 1, 2004, Child Count (618 data), in Mississippi 1.69% of infants and toddlers, birth to three, received services outlined on an IFSP, compared to states with similar eligibility criteria (broad, excluding at risk) whose average was 2.11%.

According to the December 1, 2005, Child Count (618 data), in Mississippi 1.37% of infants and toddlers, birth to three, received services outlined on an IFSP, compared to states with similar eligibility criteria (broad, including at risk) whose average was 2.74%.

According to the December 1, 2005, Child Count (618 data), in Mississippi 1.37% of infants and toddlers, birth to three, received services outlined on an IFSP, compared to states with similar eligibility criteria (broad, excluding at risk) whose average was 2.11%.

B. According to the December 1, 2004, Child Count (618 data), in Mississippi 1.69% of infants and toddlers, birth to three, received services outlined on an IFSP, compared to the national average of 2.24% (excluding at risk).

According to the December 1, 2005, Child Count (618 data), in Mississippi 1.37% of infants and toddlers, birth to three, received services outlined on an IFSP, compared to the national average of 2.24% (excluding at risk).

Discussion of Baseline Data:

Mississippi is currently serving children birth to three years of age at a rate less than the national average and less than states with similar eligibility criteria. Mississippi's Part C system falls in the broad eligibility category. Mississippi does not serve children identified as being at risk.

For this comparison, Mississippi used newly developed eligibility criteria rankings provided by OSEP based on the federal 618 Data tables submitted by states on December 1, 2004. Mississippi included our December 1, 2004 and 2005, 618 data since both were available at the time of submission of the SPP. The December 1, 2005, Child Count is considerably lower than the previous year. This drop can be accounted for by the relocation of families outside of Mississippi following Hurricane Katrina. Percentages served annually were calculated based upon the most current U.S. Census population estimates that are available with adjustments for annual state population growth.

Although the Child Count raw data indicate that we were serving 1726 infants and toddlers birth to three on December 1, 2005, during FFY2004 we served 2700 children with an IFSP during this year.

FFY	Measurable and Rigorous Targets for Indicator 6
2005 **(2005-2006)**	**1.43%** of infants and toddlers birth to 3 will have IFSPs.
2006 **(2006-2007)**	**1.53%** of infants and toddlers birth to 3 will have IFSPs.
2007 **(2007-2008)**	**1.68%** of infants and toddlers birth to 3 will have IFSPs.
2008 **(2008-2009)**	**1.78%** of infants and toddlers birth to 3 will have IFSPs.
2009 **(2009-2010)**	**1.88%** of infants and toddlers birth to 3 will have IFSPs.
2010 **(2010-2011)**	**1.98%** of infants and toddlers birth to 3 will have IFSPs.

Improvement Activities/Timelines/Resources:

Activities to commence in the second half of FFY 2005 (2005-2006)

Please refer to the activities for Indicator 5.

Activities to commence in FFY 2006 (2006-2007)

Please refer to the activities for Indicator 1.

Activities to commence in FFY 2007 (2007-2008), 2008 (2008-2009) and in FFY 2009 (2009- 2010)

Please refer to the activities for Indicator 1.

Activities to commence in FFY 2010 (2010-2011)

Please refer to the activities for Indicator 1.

Resources for Activities

Please refer to the resources for Indicator 1, unless otherwise specified.

Monitoring Priority: Effective General Supervision Part C / Child Find

Indicator 7: Percent of eligible infants and toddlers with IFSPs for whom an evaluation and assessment and an initial IFSP meeting were conducted within Part C's 45-day timeline.

(20 USC 1416(a)(3)(B) and 1442)

Measurement:

Percent = # of eligible infants and toddlers with IFSPs for whom an evaluation and assessment and an initial IFSP meeting was conducted within Part C's 45-day timeline divided by # of eligible infants and toddlers evaluated and assessed times 100.

Account for untimely evaluations.

Overview of Issue/Description of System or Process:

1. Activities are being implemented through the State Improvement Plan to address 45-day timelines, timely provision of services, natural environment, Child Find, and accurate data. Activities include training and technical assistance on the appropriate use of multidisciplinary and transdisciplinary teams for evaluation/assessment, IFSP development, and service delivery; the benefits of providing services in natural settings; and on service delivery models incorporating best practices that support the provision of early intervention services in natural environments.
2. Changes resulting from intense collaboration with the Mississippi Department of Mental Health will begin on April 1, 2006. The expansion of the District IX pilot project is enhancing the quality and timeliness of multidisciplinary evaluations/assessments; increasing awareness of early intervention eligibility criteria; improving the quality of IFSPs; and improving timely provision of services.
3. The issues affecting child find include some of the same issues affecting the 45-day timeline and timely provision of services. Improved communication and increased collaboration are needed to more effectively utilize our state's resources. The number of teams available to conduct comprehensive evaluations and assessments is limited. Many providers use a medical model for evaluations and service provision and emphasize child-centered, direct therapies versus family-centered services, routines, and functional outcomes. Current services address each area of development in isolation from other services (multidisciplinary). Evaluations and IFSP development take longer because the multidisciplinary evaluation and the IFSP must be completed using discipline-specific reports. The reports may not aid the development of IFSPs to provide services in natural environments to the maximum extent appropriate to meet the unique needs of the child and family within normal routines.
4. Clarification of data entry requirements and improvements to FSIS render the data more accurate.

Baseline Data for FFY 2004 (2004-2005):

Of the 1331 children who were referred, evaluated, and found to be eligible, 959 (72%) had an IFSP meeting in 45 days or less; 372 (28%) had an IFSP meeting in more than 45 days. Late IFSPs were due to lack of service providers to conduct evaluations in a timely manner and difficulty coordinating

evaluations with families' schedules. Because the data system was not configured to allow for electronic quantification of the justifications, the number of family-based "justifiable" reasons for missing timelines is not given. Data were obtained from the FSIS database.

Discussion of Baseline Data:

Mississippi has an Improvement Plan, which was implemented on July 1, 2005, to address the 45-day timeline requirement. Data taken on December 31, 2005, indicate that from July 1-December 31, 2005, 81% of IFSPs were developed within 45 days of initial referral. Data were obtained from the FSIS database.

FFY	Measurable and Rigorous Targets for Indicator 7:
2005 (2005-2006)	**100% of** eligible infants and toddlers with IFSPs will have an evaluation and assessment and an initial IFSP meeting conducted within Part C's 45-day timeline.
2006 (2006-2007)	**100% of** eligible infants and toddlers with IFSPs will have an evaluation and assessment and an initial IFSP meeting conducted within Part C's 45-day timeline.
2007 (2007-2008)	**100% of** eligible infants and toddlers with IFSPs will have an evaluation and assessment and an initial IFSP meeting conducted within Part C's 45-day timeline.
2008 (2008-2009)	**100% of** eligible infants and toddlers with IFSPs will have an evaluation and assessment and an initial IFSP meeting conducted within Part C's 45-day timeline.
2009 (2009-2010)	**100% of** eligible infants and toddlers with IFSPs will have an evaluation and assessment and an initial IFSP meeting conducted within Part C's 45-day timeline.
2010 (2010-2011)	**100% of** eligible infants and toddlers with IFSPs will have an evaluation and assessment and an initial IFSP meeting conducted within Part C's 45-day timeline.

Improvement Activities/Timelines/Resources:

Activities to commence in the second half of FFY 2005 (2005-2006)

1. Configure the data system to allow for electronic qualification and quantification of the justifications for missing timelines.

2. Please refer to the activities for Indicators 1 and 2.

Activities to commence in FFY 2006 (2006-2007)

Please refer to the activities for Indicator 1.

Activities to commence in FFY 2007 (2007-2008), 2008 (2008-2009) and in FFY 2009 (2009- 2010)

Please refer to the activities for Indicator 1.

Activities to commence in FFY 2010 (2010-2011)

Please refer to the activities for Indicator 1.

Resources for Activities

Please refer to the resources for Indicator 1, unless otherwise specified.

.Mississippi's Part C State Performance Plan for 2005-2010

Monitoring Priority: Effective General Supervision Part C / Effective Transition

Indicator 8: Percent of all children exiting Part C who received timely transition planning to support the child's transition to preschool and other appropriate community services by their third birthday including:

A. IFSPs with transition steps and services;
B. Notification to LEA, if child potentially eligible for Part B; and
C. Transition conference, if child potentially eligible for Part B.

(20 USC 1416(a)(3)(B) and 1442)

Measurement:

A. Percent = # of children exiting Part C who have an IFSP with transition steps and services divided by # of children exiting Part C times 100.

B. Percent = # of children exiting Part C and potentially eligible for Part B where notification to the LEA occurred divided by the # of children exiting Part C who were potentially eligible for Part B times 100.

C. Percent = # of children exiting Part C and potentially eligible for Part B where the transition conference occurred divided by the # of children exiting Part C who were potentially eligible for Part B times 100.

Overview of Issue/Description of System or Process:

1. Transition services will continue to improve as a result of the collaborative effort with local school districts which began as a "pilot project" in Health District IX. This project has already expanded from most school districts in Health District IX to some school districts in Health District VIII. Meetings are scheduled with school districts within most of the other health districts to explore similar collaborative relationships. In District IX, school districts participating in the pilot project have a representative on one of the early intervention teams that conduct comprehensive multidisciplinary evaluations and assessments. In these school districts, eligibility for Part B is considered concurrently with Part C using the same evaluation and assessment information. The developmental history was revised to meet the requirements for Part C, Part B, and the Department of Mental Health. The bulk of the information is gathered once and updated as needed. Involvement of Part B staff in the multidisciplinary evaluation/assessment for Part C enhances the transition process by increasing Part B's knowledge of their future students.
2. The specifics of the transition process vary among the health districts. Some notify the local school district soon after the child is referred to them while others wait until the transition process must begin. The materials used to inform parents of the transition process vary across the state. The stakeholder group, which met on October 25-26, 2005, recommended making the transition planning and procedures uniform across the state.

Baseline Data for FFY 2004 (2004-2005):

a) Of the 1055 children exiting Part C, transition steps and services were documented 440 times (42%). Children's names were taken from the database, but steps and services were tabulated by hand. The data included all children with birth dates between July 1, 2001, and June 30, 2002, who received EI services during the FFY 2004.

b) Of the 1015 children exiting Part C who were potentially eligible for Part B, notification to the LEA occurred 329 times (32%). Data were obtained from the FSIS database.

c) Of the 1015 children exiting Part C who were potentially eligible for Part B, the transition conference occurred 545 times (54%). Data were obtained from the FSIS database.

Discussion of Baseline Data:

FSIS does not contain fields for documenting transition steps and services. This information was requested from districts and provided through pencil/paper tabulation. Questions generated by this request indicate that SCs have difficulty determining when, which, and how to enter transition information in the current FSIS fields and the need to clearly define "potentially eligible for Part B**.**" Addressing the transition questions will result in more accurate recording of the transition activities which are occurring. Potentially eligible for Part B will be defined as "being served with an IFSP until the child's transition date or until the child is three years old."

FFY	Measurable and Rigorous Targets for Indicator 8
2005 (2005-2006)	A. **100%** of children exiting Part C will have an IFSP with transition steps and services. B. The LEA will be notified for **100%** of the children exiting Part C and potentially eligible for Part B. C. The transition conference will occur for **100%** of the children exiting Part C and potentially eligible for Part B.
2006 (2006-2007)	A. **100%** of children exiting Part C will have an IFSP with transition steps and services. B. The LEA will be notified for **100%** of the children exiting Part C and potentially eligible for Part B. C. The transition conference will occur for **100%** of the children exiting Part C and potentially eligible for Part B.
2007 (2007-2008)	A. **100%** of children exiting Part C will have an IFSP with transition steps and services. B. The LEA will be notified for **100%** of the children exiting Part C and potentially eligible for Part B. C. The transition conference will occur for **100%** of the children exiting Part C and potentially eligible for Part B.
2008 (2008-2009)	A. **100%** of children exiting Part C will have an IFSP with transition steps and services. B. The LEA will be notified for **100%** of the children exiting Part C and potentially eligible for Part B. C. The transition conference will occur for **100%** of the children exiting Part C and potentially eligible for Part B.

2009 **(2009-2010)**	A. **100%** of children exiting Part C will have an IFSP with transition steps and services. B. The LEA will be notified for **100%** of the children exiting Part C and potentially eligible for Part B. C. The transition conference will occur for **100%** of the children exiting Part C and potentially eligible for Part B.
2010 **(2010-2011)**	A. **100%** of children exiting Part C will have an IFSP with transition steps and services. B. The LEA will be notified for **100%** of the children exiting Part C and potentially eligible for Part B. C. The transition conference will occur for **100%** of the children exiting Part C and potentially eligible for Part B.

Improvement Activities/Timelines/Resources:

Activities to commence in the second half of FFY 2005 (2005-2006)

1. Encourage Part B staff to participate on the multidisciplinary teams to facilitate determining eligibility for Part B concurrently with Part C.

2. Collaborate with agencies to develop forms that meet the requirements for Part C and Part B evaluations and assessments, IFSP development and service provider documentation.

3. Potentially eligible for Part B will be defined as "being served with an IFSP until the child's transition date or until the child is three years old."

4. Develop materials which clearly describe evaluation/assessment procedures, eligibility criteria, service provision, and transition processes, including the differences between Part C and Part B.

5. Develop a handout which addresses the roles of a parent advisor, including their role in transition, and cover this information in training.

6. Collaborate with MDE parents to achieve statewide consistency in addressing the transition process, including concerns related to differences between eligibility criteria, family rights, and services under Part C and Part B.

7. Provide training and technical assistance on:

    a. Transition steps and services (the activities, documentation, and data entry):

        i) When the child qualifies for Part B services,

        ii) When the child does not qualify for Part B services; and

    b. The differences between Part C and Part B.

8. Revise FSIS to capture the transition steps and services. Transition steps and services will be included for all children who have transition during the respective FFY or who are within 9 months of their third birthday when the respective FFY ends.

9. Work with Part B to revise FSIS and MSIS so that data can be shared electronically.

10. Please refer to Indicator 1, **Activities to commence in the second half of FFY 2005,** Activity 5.

Activities to commence in FFY 2006 (2006-2007)

Please refer to the activities for Indicator 1.

Activities to commence in FFY 2007 (2007-2008), 2008 (2008-2009) and in FFY 2009 (2009- 2010)

Please refer to the activities for Indicator 1.

Activities to commence in FFY 2010 (2010-2011)

Please refer to the activities for Indicator 1.

Resources for Activities

Please refer to the resources for Indicator 1, unless otherwise specified.

Monitoring Priority: Effective General Supervision Part C / General Supervision

Indicator 9: General supervision system (including monitoring, complaints, hearings, etc.) identifies and corrects noncompliance as soon as possible but in no case later than one year from identification.

(20 U.S.C. 1416(a)(3)(B) and 1442)

Measurement:

A. Percent of noncompliance related to monitoring priority areas and indicators corrected within one year of identification:
   a. # of findings of noncompliance made related to priority areas.
   b. # of corrections completed as soon as possible but in no case later than one year from identification.

   Percent = b divided by a times 100.

   For any noncompliance not corrected within one year of identification, describe what actions, including technical assistance and/or enforcement that the State has taken.

B. Percent of noncompliance related to areas not included in the above monitoring priority areas and indicators corrected within one year of identification:
   a. # of findings of noncompliance made related to such areas.
   b. # of corrections completed as soon as possible but in no case later than one year from identification.

   Percent = b divided by a times 100.

   For any noncompliance not corrected within one year of identification, describe what actions, including technical assistance and/or enforcement that the State has taken.

C. Percent of noncompliance identified through other mechanisms (complaints, due process hearings, mediations, etc.) corrected within one year of identification:
   a. # of EIS programs in which noncompliance was identified through other mechanisms.
   b. # of findings of noncompliance made.
   c. # of corrections completed as soon as possible but in no case later than one year from identification.

   Percent = c divided by b times 100.

   For any noncompliance not corrected within one year of identification, describe what actions, including technical assistance and/or enforcement that the State has taken.

Overview of Issue/Description of System or Process:

1. The transition to a focused monitoring process will begin in May 2006, after the districts receive training on the changes in the process. The monitoring instruments and training materials are being developed. FSIS data were used to determine the order of the monitoring visits and will be used to determine priorities in conducting the monitoring visit. The focus of each district's monitoring visits will be to investigate and address factors negatively impacting EI services. The factors will be identified through data patterns, the district's self-review, informal complaints, findings of the quality monitors, and factors identified in the process of monitoring and providing technical assistance. The monitoring team will work with the district staff to identify and address the factors. The process will be tailored to address the needs in each district. Monitoring goals include identifying, enhancing and utilizing the district's strengths as well as addressing weaknesses. The goal is to have a draft improvement plan developed before the team leader leaves the health district and to provide training and technical

assistance as systemic findings and noncompliance are identified.

2. The new monitoring process will replace the current process described in the following sections. The current process has been implemented, but not systematically. Monitoring was primarily conducted as a result of informal complaints and concerns directed to the Quality Monitors or to the staff the Part C Services Branch. Documentation associated with the current approach is not quantifiable.

3. First Steps, Mississippi's Infant and Toddler Early Intervention Program, is a Division of the MDH Office of Health Services, Bureau of Child and Adolescent Health. The Division is organized into four areas of emphasis. The Division oversees all aspects of Part C implementation. It has programmatic and policy responsibility for the activities of the district early intervention staff. The Division is the primary liaison to all other public and private agencies providing early intervention services (EIS) statewide.

   The Part C Program Integrity Branch ensures the appropriate use of Part C grant funds throughout the state. The Branch monitors the expenditure of Part C resources by public health districts to ensure availability of necessary resources statewide. The Branch negotiates contracts, monitors contract terms, and supervises the monitoring of quality service delivery of services statewide with the assistance of contractual personnel and public health district staff. The Branch oversees service delivery contracts functioning in multiple public health districts.

   The Part C Services Branch oversees core implementation activities such as service coordination, child find, evaluation and assessment, individualized family service planning, service delivery, and transition processes. Additionally, the Branch oversees targeted case management (TCM), compliance monitoring activities of the public health districts, training, and technical assistance.

   Each of these branches has monitoring responsibilities that overlap at the point of service delivery to the child and family. Each is capable of identifying and correcting isolated or systemic non-compliance. The work of each branch affects training and technical assistance , service delivery, data collection, and other aspects of implementation.

   Early Hearing Detection and Intervention Program in Mississippi (EHDI-M) oversees the state's universal newborn hearing screening (UNHS) program and hearing intervention activities. This system serves as a significant source of referrals to First Steps. It also promotes personal contact with hospitals with labor and delivery services statewide. The original screening equipment was purchased with Part C funds. All UNHS equipment was replaced in 2004 with funds contributed from third party earnings from other MDH child health programs. Through UNHS greater than 96% of all live births in hospitals are screened and 100% of infants identified with bilateral hearing loss are referred to First Steps. Hearing Resource Consultants (HRCs) work directly with families and providers from screening through treatment. The HRCs are a part of the IFSP team for these children and families. This unit's activities have been reviewed by the Health Resources and Services Administration (HRSA) and received commendations for overall performance.

   Information Management oversees the First Steps Information System (FSIS) and other subordinant data collection and management activities of the division. The FSIS has been under a constant state of development/improvement to allow for the necessary collection of data to meet the 618 data reporting requirements, improve state and local management capacity, address the need to collect outcome oriented data, and to increase service coordination efficiency. Information Management supports statewide staff and provides data analysis, system design, and reports necessary to fullfill all data reporting and programmatic requirements.

   Two programs outside the Office of Health Services assist with monitoring activities. The MDH Office of Finance and Administration, Service Quality and Internal Audit programs (see monitoring Attachment 3), provide additional insight into the activities of the district and field staff. Findings are shared with district and central office staff.

Data from a variety of sources are used to identify isolated and systemic issues. The FSIS has become a formidable tool in identification of isolated and systemic noncompliance. Its utility in this arena continues to be developed. The ability to identify service delivery issues down to the child level and strengthen the integrity of the service coordination, service delivery, and monitoring processes seems to be great. We continue to work toward system enhancement to capture and report child and family outcome data as well. The following diagram depicts the monitoring processes and activities of the MDH as Part C lead agency.

Lead Agency Primary Monitoring Processes

The MDH district and county service coordination staff are all employees of the lead agency. Public Health Districts in Mississippi are not autonomous, independently functioning entities.

Process	Action
Service Coordination	The Service Coordinator monitors the delivery of EIS, parent needs, and parent/ child provider interaction to ensure consistency with Individualized Family Service Plan (IFSP) terms. This activity is on-going and required by service coordinator performance standards. Service Coordinators are required to make one family contact per month and one face-to-face contact with the family in the presence of the child quarterly. In Mississippi, service coordination is a dedicated process.
District Coordination	The District Coordinator monitors the delivery of EIS, local expenditure of funds, service coordinator activities, and coordination of activities among multiple agencies. The District Coordinator monitors the accuracy of the FSIS data continually as part of the service coordination supervision process. Ten percent of service coordination physical case records are reviewed quarterly according to monitoring requirements. Findings are documented consistent with district monitoring requirements. Annually, approximately 40% of all service coordination records are reviewed by district coordinators. District coordinators also review the documentation submitted by contractors to substantiate billing on a monthly basis. This information is compared to FSIS information to ensure consistency with the most recent IFSP. Findings meeting a specific level of significance must be reported to the First Steps Central Office. This is primarily a compliance review.
Quality Assurance	The MDH quality assurance (peer) monitors interact directly with service providers to improve the overall quality and appropriateness of EIS. The peer monitors review physical documentation and interview providers, service coordinators, and parents as part of the quality review process. All findings are submitted to the District Coordinator and the First Steps Central Office regardless of the significance. The goal of this activity is to review and report on 50% of providers regionally per year. Reports are used by the central office to ensure compliance and address the need for additional provider training on an individual or regional basis. The peer monitors conduct truly randomized reviews; conduct reviews as requested by the central office or District Coordinator, or conduct follow-up activities to ensure appropriate corrective action has been taken. This is an on-going compliance and quality review. This activity is part of the Program Integrity Branch.

Process	Action
TCM Monitoring	The MDH implemented TCM activities statewide in 2003 under a Medicaid plan amendment. To assure a high degree of accuracy in the claims filing process, a TCM monitor was placed in the Services Branch. The function of the monitor is to review cases for timeliness, accuracy, and completeness with regard to the service coordination process and individual service coordinator responsibilities. This activity encompasses a physical review of service coordination case records and an analysis of FSIS accuracy. The TCM monitor uses a combination of First Steps monitoring tools and other methods. This activity is conducted routinely and at random throughout the state. The TCM monitor's summary monitoring documents are an additional tool for ensuring compliance. Findings are shared with the District Coordinator and Service Coordinator upon exit. Requests for corrective action are prepared with the concurrence of the Services Branch Director and/or the Part C Director. District Coordinators must submit written documentation that corrective action has been taken within thirty days of the review. Follow–up reviews are scheduled as necessary to ensure corrective action has taken place. This is an on-going compliance review and is part of the Services Branch.
Interagency Monitoring	Broader in context than any process previously described, interagency monitoring ensures families have access to fluid and coordinated EIS through the Mississippi Department of Mental Health (MDMH) Regional Center Early Intervention Programs (EIPs). The MDH ensures compliance of the MDMH/EIPs through this process. Case records of the service coordinator and the MDMH program (the actual number depends upon the size of the MDMH program but it is at least 10%) are reviewed simultaneously to identify compliance issues created by interagency coordination. Corrective action plans are initiated that may require interagency training, staff meetings, and discussions. This type of review is capable of identifying individual and regional compliance issues, training needs, and overarching opportunities to improve policy and procedures. Each District Coordinator and EIP director must send a written plan of corrective action to their respective state office. Follow–up reviews are scheduled as necessary to ensure corrective action has taken place. This is an on-going compliance review. This activity is part of the Services Branch. Thirty to sixty days are allowed for corrective action to take place depending on the nature of the issue.

The implementation of the process described above has led to addressing issues of individual clients and their families but not systemic issues, other than the actions of one agency providing services resulting in termination of the contract. Coordination among the monitoring efforts began in the fall of 2005 between the quality monitors and the OMAS. Within the past six months, District Work Plans have been developed and monitored. The effectiveness of the district self review has depended on the effort of the district coordinator. Review and update of District Work Plans has not occurred on a regular basis.

Baseline Data for FFY 2004 (2004-2005):

Various systems for record keeping exist. The combination of systems does not lend itself to electronically quantifiable data regarding complaints on the local or state levels. The numbers

recorded below were obtained from District Coordinators who forwarded their data to the Central Office. The current system needs to be redesigned to allow for systematic recording of this information.

Informal complaints = Not captured in the data system
Formal signed written complaints = 0
Mediations = 0
Requests for Due Process Hearings = 0

Discussion of Baseline Data:

There was not a comprehensive system which differentiates between signed and unsigned complaints and complaints reported in writing and orally. Please refer to Indicator 10 for more discussion on complaints; Indicator 11 for more discussion on due process hearing requests that were fully adjudicated within the applicable timeline; and Indicator 13 for more discussion on mediations held that resulted in mediation agreements.

FFY	Measurable and Rigorous Targets for Indicator 9
2005 (2005-2006)	A. **100%** of noncompliance related to monitoring priority areas and indicators will be corrected within one year of identification. B. **100%** of noncompliance related to areas not included in the above monitoring priority areas and indicators will be corrected within one year of identification. C. **100%** of noncompliance identified through other mechanisms (complaints, due process hearings, mediations, etc.) will be corrected within one year of identification.
2006 (2006-2007)	A. **100%** of noncompliance related to monitoring priority areas and indicators will be corrected within one year of identification. B. **100%** of noncompliance related to areas not included in the above monitoring priority areas and indicators will be corrected within one year of identification. C. **100%** of noncompliance identified through other mechanisms (complaints, due process hearings, mediations, etc.) will be corrected within one year of identification.
2007 (2007-2008)	A. **100%** of noncompliance related to monitoring priority areas and indicators will be corrected within one year of identification. B. **100%** of noncompliance related to areas not included in the above monitoring priority areas and indicators will be corrected within one year of identification. C. **100%** of noncompliance identified through other mechanisms (complaints, due process hearings, mediations, etc.) will be corrected within one year of identification.
2008 (2008-2009)	A. **100%** of noncompliance related to monitoring priority areas and indicators will be corrected within one year of identification. B. **100%** of noncompliance related to areas not included in the above monitoring priority areas and indicators will be corrected within one year of identification. C. **100%** of noncompliance identified through other mechanisms (complaints, due process hearings, mediations, etc.) will be corrected within one year of identification.

2009 **(2009-2010)**	A. **100%** of noncompliance related to monitoring priority areas and indicators will be corrected within one year of identification. B. **100%** of noncompliance related to areas not included in the above monitoring priority areas and indicators will be corrected within one year of identification. C. **100%** of noncompliance identified through other mechanisms (complaints, due process hearings, mediations, etc.) will be corrected within one year of identification.
2010 **(2010-2011)**	A. **100%** of noncompliance related to monitoring priority areas and indicators will be corrected within one year of identification. B. **100%** of noncompliance related to areas not included in the above monitoring priority areas and indicators will be corrected within one year of identification. C. **100%** of noncompliance identified through other mechanisms (complaints, due process hearings, mediations, etc.) will be corrected within one year of identification.

Improvement Activities/Timelines/Resources:

Activities to commence in the second half of FFY 2005 (2005-2006)

1. Begin revision of the Policies and Procedures to address changes in IDEA'04.
2. Complaints, Mediation, Due Process Hearings
    a. Write procedures to address the handling of complaints, mediation, and due process hearings.
    b. Revise procedural safeguards and develop supporting training materials and information to facilitate exercising of rights.
    c. Develop necessary forms (for complaints, mediation requests, due process hearing requests, and record keeping of contacts and results).
3. Monitoring
    a. Replace the current monitoring activities with a process of focused monitoring, which includes components to identify and address compliance issues.
    b. Develop instruments.
    c. Develop training.
    d. Submit monitoring framework to OSEP, NECTAC, and SERRC for review and feedback.
4. Training and technical assistance
    a. On Family Rights (what they entail and how to effectively educate parents/guardians and caregivers);
    b. On Complaints, Mediation, and Due Process Hearings with an emphasis on problem solving to avoid a need for formal, protracted processes to resolve complaints; and
    c. On the monitoring process
        i) The reasons to monitor,
        ii) The process,
        iii) Effective record keeping and data entry, and
        iv) Effective follow-up.

5. Configure the FSIS data base to capture information about:
    a. written signed complaints,
    b. mediation requests,
    c. due process requests,
    d. correction of non-compliance, and
    e. correction of systemic performance problems related to monitoring priority areas and indicators.
6. Create and distribute a single document for making informal complaints, written signed complaints, requests for mediation, and requests for due process hearings.

Activities to commence in FFY 2006 (2006-2007)

1. Continue the changes made in the second half of 2005.
2. Evaluate the effectiveness of the above activities and make necessary changes. Utilize broad stakeholder input in this process.
3. Make changes associated with requirements in the federal regulations for Part C of IDEA'04.
4. Contract with providers willing to make needed improvements identified through the General Supervision System.
5. Provide training on:
    a. The new Policies and Procedures and
    b. The monitoring process.

Activities to commence in FFY 2007 (2007-2008)

1. Evaluate the effectiveness of the above activities and make necessary changes. Utilize broad stakeholder input in this process.
2. Provide training and technical assistance :
    a. On improvement activities identified during the monitoring process;
    b. For new district staff and service providers. The majority of this training and technical assistance will occur within each health district with follow-up through embedded training, coaching, and mentoring on a continuous basis.

Activities to commence in FFY 2008 (2008-2009)

1. Evaluate the effectiveness of the above activities and make necessary changes. Utilize broad stakeholder input in this process.
2. Provide training and technical assistance :
    a. To implement recommendations which arise from activities associated with evaluation of states' monitoring and improvement practices by the National Center for Special Education Research (NCSER) and the Institute of Education Sciences (IES).
    b. On improvement activities identified during monitoring;
    c. For new district staff and service providers. The majority of this training and technical assistance will occur within each health district with follow-up through embedded training, coaching, and mentoring on a continuous basis.

Activities to commence in FFY 2009 (2009-2010)

Please refer to the activities for Indicator 1.

Activities to commence in FFY 2010 (2010-2011)

Please refer to the activities for Indicator 1

Resources for Activities

Please refer to the resources for Indicator 1, unless otherwise specified.

Monitoring Priority: Effective General Supervision Part C / General Supervision

Indicator 10: Percent of signed written complaints with reports issued that were resolved within 60-day timeline or a timeline extended for exceptional circumstances with respect to a particular complaint.

(20 U.S.C. 1416(a)(3)(B) and 1442)

Measurement:
Percent = (1.1(b) + 1.1(c)) divided by (1.1) times 100.

Overview of Issue/Description of System or Process:

When parents are given the Family Rights brochure, they are informed of their right to file complaints and are given the First Steps Central Office toll-free number. Complaints are received on both the local and state levels. Neither the manner in which the complaints are tracked or the forms used to record them are standard. There is not a process for the health districts to systematically report complaints received, action taken, and resolution of the complaint. The only exception is that they are to report to the First Steps Central Office any findings which cannot be resolved at the district level.

Baseline Data for FFY 2004 (2004-2005):

Signed written complaints received at the First Steps Central Office = 0

Signed written complaints with reports issued that were resolved within 60-day timeline or a timeline extended for exceptional circumstances = N/A

Discussion of Baseline Data:

No signed written complaints have been received at the district or state level in three years. On the state level informal complaints have been handled by central office staff by either addressing the involved parties directly or by conducting a site visit. A main function of the quality monitors has been to investigate informal complaints. On the local level, the DC or DA has addressed complaints. A uniform formal method of documenting complaints needs to be developed for use at both the district and state levels. The database needs to be configured to capture information about signed written complaints.

FFY	Measurable and Rigorous Target for Indicator 10
2005 (2005-2006)	100% of signed written complaints with reports issued will be resolved within a 60-day timeline or a timeline extended for exceptional circumstances with respect to a particular complaint.
2006 (2006-2007)	100% of signed written complaints with reports issued will be resolved within a 60-day timeline or a timeline extended for exceptional circumstances with respect to a particular complaint.
2007 (2007-2008)	100% of signed written complaints with reports issued will be resolved within a 60-day timeline or a timeline extended for exceptional circumstances with respect to a particular complaint.

2008 (2008-2009)	100% of signed written complaints with reports issued will be resolved within a 60-day timeline or a timeline extended for exceptional circumstances with respect to a particular complaint.
2009 (2009-2010)	100% of signed written complaints with reports issued will be resolved within a 60-day timeline or a timeline extended for exceptional circumstances with respect to a particular complaint.
2010 (2010-2011)	100% of signed written complaints with reports issued will be resolved within a 60-day timeline or a timeline extended for exceptional circumstances with respect to a particular complaint.

Improvement Activities/Timelines/Resources:

Activities to commence in the second half of FFY 2005 (2005-2006)

1. Develop procedures to ensure that families, guardians, caregivers, providers, and others involved with the provision of early intervention services are knowledgeable and empowered to advocate for the rights of families of children in need of and eligible for early intervention services,
2. Develop communication notebooks, which include among other valuable information procedural safeguards in a user-friendly format; the MDH/EI toll free #; contact information for advocacy groups; forms for filing informal and signed written complaints, requesting mediation, and requesting due process hearings; and sample letters for documenting requests for changes in services, documentation, etc.
3. Training for
    a. Families on the process, procedures, and forms used to exercise rights and to get relief and remedy;
    b. District staff on the process, procedures, forms, and materials to teach families about exercising their rights;
    c. Providers on the process, procedures, forms, knowledge, and skills families need to exercise their rights;
    d. Advocacy groups and other stakeholders on the process, procedures, forms, and materials provided to families describing their rights and how to exercise them.
4. Explore the possibility of contracting with a Parent Advisor at the state level for monitoring, coordinating the Family Outcome activities, linking parents to advocacy groups, and training and technical assistance.
5. Configure the database to capture information about signed written complaints.
6. Create and distribute a single document for making informal complaints, written signed complaints, requests for mediation, and requests for due process hearings.
7. Please refer to the activities for Indicator 9 **to commence in the second half of FFY 2005.**

Activities to commence in FFY 2006 (2006-2007)

Please refer to the activities for Indicator 9.

Activities to commence in FFY 2007 (2007-2008)

Please refer to the activities for Indicator 9.

Activities to commence in FFY 2008 (2008-2009)

Please refer to the activities for Indicator 9.

Activities to commence in FFY 2009 (2009-2010)

Please refer to the activities for Indicator 1.

Activities to commence in FFY 2010 (2010-2011)

Please refer to the activities for Indicator 1.

Resources for Activities

Please refer to the resources for Indicator 1, unless otherwise specified.

Monitoring Priority: Effective General Supervision Part C / General Supervision

Indicator 11: Percent of fully adjudicated due process hearing requests that were fully adjudicated within the applicable timeline.

(20 U.S.C. 1416(a)(3)(B) and 1442)

Measurement:

Percent = (3.2(a) + 3.2(b)) divided by (3.2) times 100.

Overview of Issue/Description of System or Process:

We need to put a process in place. There have been no due process hearing requests in the history of EI in Mississippi. This is likely due in part to the fact that the Family Rights two-page summary explained to parents/guardians describes a process for filing complaints but makes no reference to mediation or due process hearings. The section of the two page summary covering this content reads as follows:

> *"The right to disagree:* If you disagree with any of the recommendations made for your child or think he/she is not receiving the services needed, you have a right to voice your concerns. If you have a complaint to make, you can call your service coordinator or call the Mississippi Early Intervention Program at 1-800-451-3903.
>
> I, _____, parent(s) of_____ verify the above rights and procedures have been explained to me on this date, _____, and I understand if I have further questions or concerns I may call or write for explanation."

The Family Rights brochure given to the parents includes information about due process hearings but the content is not included in the documentation signed by the parent(s). The instructions in the Service Coordinator manual read as follow: "A copy of the detailed Family Rights pamphlet, including a glossary of terms, will be given to the parents, along with appropriate explanations of any of its concerns." Another possible explanation for successful resolution of informal complaints is the way choices have been offered to parents. The policy by and large has been that "Whatever parents want, parents get," whether the team agreed on the appropriateness of the request or it complied with regulations.

Baseline Data for FFY 2004 (2004-2005):

Due Process Hearing requests = 0

Discussion of Baseline Data:

There have been no due process hearing requests in the history of EI in Mississippi. It is uncertain what percent of parents or guardians know that they can request mediation or a due process hearing. The two page Family Rights handout which must be covered with the parent/guardian mentions complaints but not mediation or due process hearings. Also, the parents have the right to decline some EI services while accepting other EI services. Having this right to decline some EI services makes it less likely that disagreements will escalate to a due process hearing request. The FSIS

database needs to be configured to capture information about due process hearings.

FFY	Measurable and Rigorous Target for Indicator 11
2005 (2005-2006)	**100%** of due process hearing requests will be fully adjudicated within the 30 day timeline.
2006 (2006-2007)	**100%** of due process hearing requests will be fully adjudicated within the 30 day timeline.
2007 (2007-2008)	**100%** of due process hearing requests will be fully adjudicated within the 30 day timeline.
2008 (2008-2009)	**100%** of due process hearing requests will be fully adjudicated within the 30 day timeline.
2009 (2009-2010)	**100%** of due process hearing requests will be fully adjudicated within the 30 day timeline.
2010 (2010-2011)	**100%** of due process hearing requests will be fully adjudicated within the 30 day timeline.

Improvement Activities/Timelines/Resources:

Activities to commence in the second half of 2005 (2005-2006)

1. Make arrangements to have
    a. Hearing officers available when needed; and
    b. Information regarding the forms and process available on the department's website and printed in the languages spoken by our clients' families.
2. Provide training for hearing officers, families, advocacy groups, district staff, First Steps Central Office staff and other stakeholders on Family Rights and Procedural Safeguards.
3. Please refer to the activities for Indicators 9 and 10.

Activities to commence in FFY 2006 (2006-2007)

Please refer to the activities for Indicator 9.

Activities to commence in FFY 2007 (2007-2008)

Please refer to the activities for Indicator 9.

Activities to commence in FFY 2008 (2008-2009)

Please refer to the activities for Indicator 9.

Activities to commence in FFY 2009 (2009-2010)

Please refer to the activities for Indicator 1.

Activities to commence in FFY 2010 (2010-2011)

Please refer to the activities for Indicator 1.

Resources for Activities

Please refer to the resources for Indicator 1, unless otherwise specified.

Monitoring Priority: Effective General Supervision Part C / General Supervision

Indicator 12: Percent of hearing requests that went to resolution sessions that were resolved through resolution session settlement agreements (applicable if Part B due process procedures are adopted).

(20 U.S.C. 1416(a)(3)(B) and 1442)

Measurement:

Percent = 3.1(a) divided by (3.1) times 100.

Overview of Issue/Description of System or Process:

Not applicable for First Steps because Part B due process procedures have not been adopted by First Steps.

Monitoring Priority: Effective General Supervision Part C / General Supervision

Indicator 13: Percent of mediations held that resulted in mediation agreements.

(20 U.S.C. 1416(a)(3)(B) and 1442)

Measurement:
Percent = (2.1(a)(i) + 2.1(b)(i)) divided by (2.1) times 100.

Overview of Issue/Description of System or Process:

The First Steps Early Intervention Program Standards and Procedures, May 2001, describe a mediation process. The Family Rights brochure given to parents includes information about mediation, but the content is not included in the documentation explained to parents/guardians by the service coordinator.

Baseline Data for FFY 2004 (2004-2005):

Mediations = 0

Discussion of Baseline Data:

There have been no mediation requests in the history of EI in Mississippi. It is uncertain whether parents/guardians know that they can request mediation or a due process hearing. The two page Family Rights handout which must be covered with the parent/guardian mentions complaints but not mediation or due process hearings. Also, the parents have the right to decline some EI services while accepting other EI services. Having this right to decline some EI services makes it less likely that disagreements will escalate to a due process hearing request. The FSIS database needs to be configured to capture information about mediation.

FFY	Measurable and Rigorous Targets for Indicator 13:
2005 (2005-2006)	**Based on OSEP guidance, States should not set targets for Indicator 13 unless its baseline data reflect that it has received a minimum threshold of 10 mediation requests.**
2006 (2006-2007)	
2007 (2007-2008)	
2008 (2008-2009)	

2009 (2009-2010)	
2010 (2010-2011)	

Improvement Activities/Timelines/Resources:

Activities to commence in the second half of FFY 2005 (2005-2006)

4. Refer to Activity #2 in Indicator 9.
5. Make arrangements to have
    a. Trained mediators available when needed; and
    b. Information regarding the forms and process available on the department's website and printed in the languages spoken by our clients' families.
6. Provide training for mediators, families, advocacy groups, district staff, First Steps Central Office staff and other stakeholders on Family Rights and Procedural Safeguards.
7. Please refer to the activities for Indicators 9 and 10.

Activities to commence in FFY 2006 (2006-2007)

Please refer to the activities for Indicator 9.

Activities to commence in FFY 2007 (2007-2008)

Please refer to the activities for Indicator 9.

Activities to commence in FFY 2008 (2008-2009)

Please refer to the activities for Indicator 9.

Activities to commence in FFY 2009 (2009-2010)

Please refer to the activities for Indicator 1.

Activities to commence in FFY 2010 (2010-2011)

Please refer to the activities for Indicator 1.

Resources for Activities

Please refer to the resources for Indicator 1, unless otherwise specified.

Monitoring Priority: Effective General Supervision Part C / General Supervision

Indicator 14: State reported data (618 and State Performance Plan and Annual Performance Report) are timely and accurate.

(20 U.S.C. 1416(a)(3)(B) and 1442)

Measurement:

State reported data, including 618 data, State Performance Plan, and Annual Performance Reports, are:

a. Submitted on or before due dates (February 1 for child count, including race and ethnicity, settings and November 1 for exiting, personnel, dispute resolution); and

b. Accurate (describe mechanisms for ensuring accuracy).

Overview of Issue/Description of System or Process:

1. The validity and reliability of the other indicator measures are dependent on accurate data reported in a timely manner. When monthly reports are run, records with incomplete data and records with illogical combinations of dates are identified. Central Office staffs notify DCs and SCs of possible problems. Deadlines are set staff follow up to make sure corrections are made or plausible explanations are documented. A more systematic means of checking data accuracy has not been developed. However, new automated reports are available to C.O. staff and District Coordinators through FSIS.
2. In July 1, 2005, the process of transferring data to a centralized network system began. The server is housed at the C.O. Importing and exporting data are no longer required, nor can data be "lost" at the district level.
3. Districts I through VIII have transferred all data to the network system as of December 31, 2005. In District IX the delay in changing from the old data system to the network system is due to displaced workers, damaged offices, and lost equipment as a result of Hurricane Katrina.
4. Duplicate ID numbers for children has been an issue. Guidance about making up ID numbers has resulted in fewer duplicate numbers and fewer merged records.
5. Issues of accurate and timely entry of data are being addressed at the district level by policies and established deadlines. The state definition of timely emphasizes that data will be checked more than once monthly and should be as accurate and current as possible. Frequent data checks and audits have increased data are accuracy and timeliness.

Baseline Data for FFY 2004 (2004-2005):

1. State reported data, including 618 data, the State Performance Plan, Annual Performance Reports, and data related to the Improvement Plan are submitted to OSEP on or before due dates. The reports are based on the data reported by the districts and from information from monitoring visits.

2. With each monthly report being generated, the data appear to be more complete, in that fewer data fields are blank, there are fewer instances of illogical dates, and the total raw numbers continue to increase at an expected increment.

Discussion of Baseline Data:

1. Null reports are a tool available to district staff to use to flag missing data. Lack of time to devote to data entry or waiting for information from a provider were reasons frequently given for missing data.
2. Accuracy of data:
    a. Reviews of data falling outside of acceptable ranges suggest typing mistakes, problems with interpreting the meaning of data fields, as well as procedural errors in implementing the EI program.
    b. Because of the dynamic nature of data, all relevant data fields will never be entered for all 60+ Service Coordinators and thousands of cases at a single point in time. However, the data (especially percentages) do appear to be representative of the district data and state data as a whole.

FFY	Measurable and Rigorous Targets for Indicator 14:
2005 (2005-2006)	a. 100% of state reported data, including 618 data, State Performance Plan, and Annual Performance Reports will be submitted on or before due dates. b. 100% of state reported data, including 618 data, State Performance Plan, and Annual Performance Reports will be accurate.
2006 (2006-2007)	a. 100% of state reported data, including 618 data, State Performance Plan, and Annual Performance Reports will be submitted on or before due dates. b. 100% of state reported data, including 618 data, State Performance Plan, and Annual Performance Reports will be accurate.
2007 (2007-2008)	a. 100% of state reported data, including 618 data, State Performance Plan, and Annual Performance reports will be submitted on or before due dates. b. 100% of state reported data, including 618 data, State Performance Plan, and Annual Performance Reports will be accurate.
2008 (2008-2009)	a. 100% of state reported data, including 618 data, State Performance Plan, and Annual Performance Reports will be submitted on or before due dates. b. 100% of state reported data, including 618 data, State Performance Plan, and Annual Performance Reports will be accurate.
2009 (2009-2010)	a. 100% of state reported data, including 618 data, State Performance Plan, and Annual Performance Reports will be submitted on or before due dates. b. 100% of state reported data, including 618 data, State Performance Plan, and Annual Performance Reports will be accurate.
2010 (2010-2011)	a. 100% of state reported data, including 618 data, State Performance Plan, and Annual Performance Reports will be submitted on or before due dates. b. 100% of state reported data, including 618 data, State Performance Plan, and Annual Performance Reports will be accurate.

Improvement Activities/Timelines/Resources:

Activities to commence in the second half of 2005 (2005-2006)

1. Define "timely entry of data:" Timely entry of data will be the entry of data no later than 10 calendar days after the event occurs. Stakeholders recommended a weekly schedule for data entry by SCs responsible for each case. District personnel will make local procedures regarding schedules for data entry. When a deadline for a report is approaching, the District Coordinators will be responsible for ensuring that the report data are accurate.
2. A central referral system:
    a. All initial referrals will be sent to the Central Office.
    b. Central Office personnel will enter the referral information into the database.
    c. The database will assign a unique identifying # to each child.
    d. Central Office staff will notify the District Coordinator (DC) of the referral as soon as possible on the date the referral is received. Contact with the district will be documented on the referral form.
    e. The process used at the FS-CO will be monitored by both self-review within the FS-CO and by contract staff during unannounced monitoring visits.
3. The First Steps Information System (FSIS):
    a. When FS-CO staff members are in district offices, they will enter data and contact C.O. staff to check the state database for consistency. The staff member in the FS-CO will print out the entered information and the staff member in the district office will do the same. The samples will be compared for consistency.
    b. District personnel will print null reports and enter missing data at least once weekly.
    c. Central Office staff and the DC's will print district reports to check for missing data, 45-day timelines, timely provision of services, services within the natural environment, and justifications. Service Coordinators will be notified of questionable or missing data. Deadlines will be set for "clean up," with follow up before reports are finalized.
4. Methods of verifying accuracy of data at the district level:
    a. District Coordinators will be responsible for self-review using available reports and audits of records;
    b. Focused Monitoring: Systematic checking for data accuracy will be part of the focused monitoring visit to ensure that the data reported reflect the EI activity within the health district. This will occur during:
        i) Announced monitoring visits,
        ii) Unannounced monitoring visits, and
        iii) Follow-up on Improvement Plans.

5. Training on:

    a. Data entry;

    b. Self-assessment;

    c. The focused monitoring process for districts and the monitoring team members; and

    d. Service Coordination and EI procedures effecting data entry and reporting.

6. Central Office staff will continue to work with District IX:
    a. as they recreate their data, including data entry, when necessary;
    b. by assisting them in continually assessing their needs; and
    c. by providing man-power, if needed, to assist them as they rebuild the infrastructure of Early Intervention.

Activities to commence in 2006 (2006-2007)

Please refer to the activities for Indicators 1.

Activities to commence in FFY 2007 (2007-2008), 2008 (2008-2009) and in FFY 2009 (2009- 2010)

Please refer to the activities for Indicators 1.

Activities to commence in FFY 2010 (2010-2011)

Please refer to the activities for Indicators 1.

Resources for Activities

Please refer to the resources for Indicator 1, unless otherwise specified.

Part C – SPP Attachment 1

Report of Dispute Resolution Under Part C of the Individuals with Disabilities Education Act Complaints, Mediations, Resolution Sessions, and Due Process Hearings

SECTION A: Signed, written complaints	
(1) Signed, written complaints total	0
(1.1) Complaints with reports issued	0
(a) Reports with findings	0
(b) Reports within timeline	0
(c) Reports within extended timelines	0
(1.2) Complaints withdrawn or dismissed	0
(1.3) Complaints pending	0
(a) Complaints pending a due process hearing	0
SECTION B: Mediation requests	
(2) Mediation requests total	0
(2.1) Mediations	
(a) Mediations related to due process	0
(i) Mediation agreements	0
(b) Mediations not related to due process	0
(i) Mediation agreements	0
(2.2) Mediations not held (including pending)	0
SECTION C: Hearing requests	
(3) Hearing requests total	0
(3.1) Resolution sessions	0
(a) Settlement agreements	0
(3.2) Hearings (fully adjudicated)	0
(a) Decisions within 30-day timeline	0
(b) Decisions within extended timeline	0
(3.3) Resolved without a hearing	0